INCREASING ENROLLMENT IN PROJECT GOOD HEALTH:

A Report to the Commissioner

Office of Research, Planning and Evaluation
Department of Public Welfare
Commonwealth of Massachusetts

January 1985

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FOREWORD

In August 1983 the Commissioner of Public Welfare, Charles M. Atkins, announced that as one of the management goals for the Department of Public Welfare in Fiscal Year 1984 (July 1, 1983 to June 30, 1984), Project Good Health (PGH) was to increase its enrollment to 50,000 children. For Fiscal Year 1985, the Department's goal is a further increase in PGH enrollment to include 50 percent of all eligible children. By setting these goals, the Commissioner acknowledged the importance of quality preventive health care for the Commonwealth's children and the agency's commitment to greater access to services for its clients.

The Commissioner assigned to the Office of Research, Planning and Evaluation the task of evaluating the program and making recommendations as to how enrollment could be increased. The study was to focus on three areas: (1) increased participation of eligibles, including especially underserved groups such as adolescents and non-English speaking families; (2) increased enrollment of doctors and other health care providers; and (3) structural changes in the program which could lead to increased enrollment.

The Research, Planning and Evaluation staff who worked on the report included: Elizabeth Vorenberg, Assistant Commissioner; Carol VanDeusen Lukas, Director of Evaluation; Kathryn Porter, who directed the PGH study; Hope Berger; Alison Bowen; Jessica Banthin; Jean Marino and Julia Bennett.

To assist the evalution staff, the Commissioner created an Advisory Committee which consisted of the following members:

Suzanna Alvarez, M.D.
Martha Eliot Family Health Center and Children's Hospital

Stephen Bing, Executive Director
Massachusetts Advocacy Center

Tristram Blake, Executive Director
South End Community Health Center
Immediate Past President of the Massachusetts League of Community Health Centers (1981-1983)

Corinne Borman, Director of Nutrition
Lynn Community Health Center

Walter Harrison, M.D.
Pediatrician

Helen Patterson, Acting Executive Director
Massachusetts Committee for Children and Youth
(resigned December 1, 1984)

Robert M. Reece, M.D.
Department of Pediatrics, Boston City Hospital
Secretary of the Massachusett Chapter of the
American Academy of Pediatrics (1981-1984)

Ala Reid, Administrator
Grants Management Associates

The Committee met for the first time on April 9, 1984 and concluded its deliberations on December 18, 1984. Between meetings, committee members read voluminous materials and were available for phone consultations. Their assistance and insights were invaluable in shaping the findings of this report.

The Office of Research, Planning, and Evaluation (RP&E) received extensive assistance and cooperation from many other Department staff. In the Central Office, Virginia Jacobs, the Director of Coordinated Health Programs; Lynne Karsten, the Director of PGH; and PGH staff members Daniel Shea, Elizabeth Pressman, and Rosemary Pellettieri were especially helpful. In the local offices, virtually the entire PGH field staff participated in the evaluation. The RP&E evaluation staff is grateful for the continuing cooperation of the PGH staff. The evaluation staff is also grateful for the much needed assistance provided by the Department's Word Processing unit.

This report is based on data and information from a number of sources including:

- o interviews with Central Office personnel involved with PGH;
- o an analysis of the PGH marketing strategies completed by the Research, Planning and Evaluation Office in May 1984;
- o visits to several PGH sites;
- o a telephone survey in May 1984 of 400 AFDC recipients who were asked about the frequency and sources of their health care;
- o a survey mailed to all PGH field staff which asked about outreach efforts to PGH eligible families, provider relations, and general PGH management and structural issues;
- o interviews with pediatricians throughout the state who recommended improvements in the PGH program to increase physician participation;
- o an interview with the attorneys representing the plaintiffs in the Vega suit;
- o client and provider enrollment statistics program data, memoranda, and program cost information from the PGH and Budget Office staff;
- o literature reviews and informal telephone surveys of EPSDT activities in other states;
- o interviews with possible alternative providers for PGH.

A list of persons interviewed can be found in Appendix K. Other data sources are described in the body of the report. The data were collected primarily between March and August of 1984. However, to the extent that changes in the program were made during the course of this study, they have been noted as much as possible.

Every effort was made to evaluate the program carefully and with an appreciation what has been achieved, especially in the past three years. The Committee supports the goals of the program and hopes that its recommendations will further strengthen the program's objectives.

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EXECUTIVE SUMMARY

Project Good Health (PGH) is a program of the Department of Public Welfare which provides quality preventive health care to children under 21 who are eligible for Medicaid. Children who are enrolled in Project Good Health receive regular medical examinations at specified intervals, following a standard protocol. These examinations are given by a physician or other medical care provider who participates in the Medicaid program.

The Commonwealth established PGH in 1972 in response to an amendment to the Federal Medicaid law requiring every state to develop an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for Medicaid eligible children. In Massachusetts, the operation of PGH is governed not only by Federal regulations, but also by a 1978 court stipulation resulting from a lawsuit brought against the Department of Public Welfare. The stipulation from Vega v. Moran commits the Department to specified outreach procedures designed to ensure that all eligible families are informed of the availability of PGH services.

Increasing the enrollment in PGH to 50 percent of the eligible children is a priority goal for the Department of Public Welfare. Currently in Massachusetts, there are approximately 215,000 Medicaid recipients under the age of 21, all of whom are eligible for quality preventive health care under PGH. As of July 1984, 26 percent of these children were enrolled in the program. Several groups of eligible children, including adolescents, children from non-English speaking families, and children in the care and custody of state agencies, are especially underrepresented in Project Good Health.

Although the proportion of eligible children enrolled in PGH has not yet reached the 50 percent goal, current statistics indicate a substantial increase in program participation. In 1980, the plaintiffs in Vega v. Moran charged that only 6 percent of the total eligible population was participating. A 1977 publication of the Children's Defense Fund ranked Massachusetts 48th among the states in number of screens provided per eligible child.

This report presents findings and recommendations from an evaluation of PGH conducted by the Office of Research, Planning and Evaluation of the Department of Public Welfare. The study focused on identifying problems in current enrollment strategies and developing recommendations as to how enrollment could be further increased. The report also delineates the programmatic and administrative changes necessary to pursue alternative enrollment strategies.

To understand the barriers to client enrollment and analyze how current enrollment strategies could be improved, the evaluation staff examined both field worker outreach and provider recruitment activities. In addition, the staff reviewed and analyzed several alternative approaches: an expansion of the service delivery and recruitment network to include other health providers, and organizations and agencies that are already in contact with PGH

eligible families; and redefinition of the role of the field worker and of the overall administrative structure. For each of these, the staff developed a set of recommendations based upon the findings of its inquiry. The major recommendations have been included in the Executive Summary. More detailed recommendations are contained in Chapter VII.

CURRENT OUTREACH EFFORTS

Eligible families gain access to PGH services either through the assistance of PGH field workers or through health care providers who participate in PGH. Four-fifths of the staff of Project Good Health are field workers stationed in local welfare offices. However, even with this large allocation of staff, three-fourths of the children who receive PGH services enroll because they happen to go to a medical care provider who participates in the PGH program. The PGH field staff accounts for only about one-quarter of the children enrolled in the program.

The Federal and court requirements for maximizing the number of families who receive PGH services focus on extensive procedures for notifying eligible clients of the availability of services. To carry out these procedures the 51 PGH specialists and technicians who work in local welfare offices send information on the program to all eligible families and attempt to contact by phone those families who request help or whose records indicate a lack of regular medical or dental care.

The methods for enrolling eligible children prescribed by Federal and court requirements and implemented by PGH field workers produce few results for the effort they entail. The majority of eligible families have regular sources of medical care outside of PGH. With no tangible incentives offered by PGH, they are unlikely to change to a PGH provider, particularly if the PGH provider is less accessible to them. They are most likely to be brought into PGH through the recruitment of their regular health care provider. As the findings indicate, three-fourths of the current PGH enrollment originates with providers.

The present emphasis on letters and phone calls is even more problematic in the recruitment of the significant proportion of families who do not have a regular source of medical care. For a family that does not have regular contact with a medical care provider, and is under a great deal of financial stress, preventive medical care may not be a high priority.

Additional cultural and language barriers further limit the access of families that do not speak English or are recent immigrants. Limited contact with a PGH worker, particularly when the worker does not speak their language, may not help them understand the services offered or the value of preventive medical care.

Adolescents also present special problems. They have the lowest PGH participation of any age group. Outreach workers rarely have direct contact with adolescents. Even in families where other members receive routine health care, adolescents tend not to seek health care for themselves.

Bringing these families and individuals into PGH will require both persuasion that preventive health care is worthwhile and assistance in locating health care. They are most likely to become enrolled in PGH through agencies,

institutions, and private organizations that are easily accessible to them and with which they already have regular contact, or through more personal, face-to-face contact with PGH field staff.

PROVIDER RECRUITMENT

The recruitment of health care providers into PGH has received far less attention than the recruitment of clients. While the field staff has numbered more than 50, until recently only one person handled both provider recruitment and ongoing relations with PGH providers.

Most recruitment efforts have been directed to individual physicians, predominantly pediatricians. As of November 1984, only 14 out of 496 medical care providers participating in PGH were not individual physicians. Yet close to half of the PGH eligible families statewide, and a higher proportion in some areas, use providers other than individual physicians as their regular source of medical care. A survey of eligible families revealed the following pattern:

- o 57% go to private physicians;
- o 23% go to community health centers;
- o 18% go to hospital clinics.

Even among the individual physicians enrolled in the Medicaid program (and therefore available to provide PGH services), the majority do not participate in the program. As of November 1984, only 357 of the 815 pediatricians who accept Medicaid were providing PGH services. The proportion of other primary care physicians participating in the program is even lower. Moreover, participation by individual physicians is unevenly distributed across the state. This means that PGH-eligible families in some parts of the state are unlikely to have access to PGH providers.

Recommendations

1. Project Good Health should expand its recruitment of medical care providers other than individual physicians by:
   - o working with community health centers to remove barriers created by PGH procedures;
   - o contacting independent physicians who practice in outpatient departments of hospitals;
   - o exploring the feasibility of recruiting hospital-licensed health centers;
   - o enrolling continuing care providers under new Federal regulations.
2. Program administrators should respond to physicians' apprehension about PGH's cumbersome program procedures by:
   - o informing physicians about recent simplified procedures;

- o continuing review of physicians' suggestions for reduced paperwork;

- o providing technical assistance to physicians through reviews of their records designed to assist them in correcting weaknesses in their recordkeeping procedures;

- o creating an ongoing advisory committee of physicians to provide more communication between physicians and program administrators.

3. The PGH provider recruitment staff should increase their efforts with physicians who have not previously participated in PGH in large numbers: general and family practitioners, internists, gynecologists, and female physicians.

THE EXPANSION OF THE RECRUITMENT SYSTEM AND SERVICE DELIVERY SYSTEM

A substantial proportion of the children eligible for Project Good Health do not receive regular well-child medical care. Current PGH outreach efforts already give top priority to these children, but PGH outreach has failed to enroll most of them. Estimates of the proportion of eligible children who do not receive regular medical and dental care range from about 20 percent, based on self-reports of eligible families surveyed, to about 55 percent, based on an analysis of data reported by selected local offices.

Adolescents, non-English speaking families, some infants, and children in the care and custody of state agencies are particularly at risk of not receiving regular medical care or PGH services. These groups are unlikely to be reached through an intensification of current outreach methods such as letters and phone calls.

A variety of government agencies and private organizations are already accessible to and in touch with these target populations. Careful consideration should be given to the potential of reaching children and adolescents without medical care or medical access through an expanded service delivery and recruitment system that includes family planning clinics, community organizations, hospitals, school health programs, preschool programs, state agencies with children in their care and custody, and public health agencies.

As an example, family planning clinics and school health programs could all play important roles in making PGH services accessible to adolescents. By linking up with the Department of Public Health's special nutrition outreach effort to Southeast Asian immigrants, and by contracting with selected community organizations, PGH could greatly expand its recruitment of non-English speaking families. Children in the care and custody of the Departments of Social Services, Youth Services, and Mental Health would all benefit from the full implementation of agreements recently reached between each of these state agencies and PGH.

Many of these organizations and agencies, however, present issues that must be resolved if they are to become part of an expanded PGH recruitment and delivery system. A number of the key steps PGH should take to create this new system are outlined below.

Recommendations:

1. The Department should try to resolve outstanding issues with family planning clinics and renew its efforts to enroll these agencies as PGH providers by:

    o providing alternate means of verifying the Medicaid eligibility of adolescents;

    o setting up a process to resolve the confidentiality and client tracking problems.

2. PGH should increase its outreach to non-English speaking families by:

    o taking immediate steps to include PGH in the Women, Infant and Children's program's special outreach to Southeast Asian refugees;

    o developing a plan for awarding small grants to community organizations to reach out to non-English speaking families.

3. The PGH administrators should develop a plan for enrolling all Medicaid eligible newborns in PGH through the hospitals, by:

    o working with hospital staff to identify and inform Medicaid eligible families;

    o working with staff in the Department of Public Health (DPH) high risk infant identification program to identify and contact the parents of PGH-eligible children in that group.

4. PGH should take advantage of the potential of elementary and high school health programs for reaching large numbers of children eligible for PGH, by:

    o identifying and, where appropriate, recruiting as PGH providers school systems that currently offer comprehensive health care to their students;

    o working with DPH and the Department of Education to develop a plan for referring to PGH school-aged children who are not receiving regular health care.

5. PGH should continue current efforts to inform preschool and day care programs about PGH, by:

    o considering contracts with Head Start programs to recruit children to PGH;

    o meeting with Head Start health coordinators and parents;

    o collaborating with Public Health staff to produce a health manual for day care providers.

6. PGH should formalize the role of DPH staff in the recruitment and referral of families to PGH by:

   - o negotiating with DPH staff to include the PGH protocol and periodicity schedule in all Public Health contracts with Family Health providers;

   - o considering performance-based contracts with DPH to recruit children to PGH.

RESTRUCTURING OF STAFF ROLES AND RESPONSIBILITIES

PGH field workers are responsible for contacting new client families and providing certain types of assistance to eligible families, including referrals to medical and dental providers, or help with transportation or child care. In addition, the workers are responsible for tracking children enrolled in PGH, monitoring whether they receive the required number of screenings at the designated times and receive the necessary follow-up treatment. Much of their work is dictated by Federal regulations and a court stipulation.

As a result, PGH field workers report they spend between 9 and 17 hours per week sending out letters to all newly eligible families, even though letters produce the fewest contacts of any outreach methods used. The considerable time spent making telephone calls is only slightly more productive. Because of the paperwork they are required to do, PGH workers rarely have time for in-person interviews which offer the best payoff in recruiting new families.

In carrying out their responsibilities, PGH workers rely on support and resources from local welfare offices, as well as from the Central Office. In order to contact families eligible for PGH, the workers rely on information obtained by the AFDC and Medicaid eligibility workers during the application interview. Yet many PGH workers feel that they do not get enough information from these workers and express dissatisfaction with the forms on which the information is collected.

The problem of support may be exacerbated by the administrative structure. Field workers do not receive day-to-day, onsite supervision. Although PGH field staff work in local welfare offices, they do not report to the local office director. Most local office staff are supervised through the Division of Eligibility Operations (DEO), the part of the Department responsible for the day-to-day operations of the local offices. In contrast, all PGH field staff are supervised by one of six rotating PGH supervisors who report to the PGH field coordinator in the Central Office and may only see an individual PGH worker once a week.

In addition to the explicit responsibilities spelled out in both Federal regulations and court stipulations, PGH workers spend a significant amount of their time helping adults not eligible for PGH. In the course of contacting families with children who are eligible for the program, the worker is often asked for information concerning the health care of other family members. Because the PGH worker is the only person in a local office whose responsibilities include assistance in health matters, adults often come to the PGH worker for help, or are referred to the worker by other local office staff. The PGH workers thus function as de facto "health specialists."

Recommendations

1. The paperwork required of the PGH field workers should be reduced by:

   o sending out the required outreach letters and informational materials from the Department's Central Office;

   o examining the current reporting and data verification activities of the field staff to determine whether activities could be eliminated or centralized.

2. The field staff should engage in more active and targeted outreach strategies, including more personal contact with eligible families and individuals. The PGH administration should encourage this by holding workers accountable for meeting:

   o monthly goals for the number of children enrolled by each worker;

   o monthly goals for the number of in-person interviews with potential participants.

3. The Department should seek to vacate the Vega stipulation, or, alternatively, attempt to have the stipulation modified so that the provisions of the stipulation are consistent with those of the new Federal regulations. Among other areas, these changes are needed to give the Department discretion to improve the effectiveness of PGH outreach.

4. The Department should consider designating PGH workers as "health specialists," in recognition of their important role in providing health information and assistance to the entire Medicaid population. The health specialists' duties could include:

   o enrolling eligible children in PGH;

   o recruiting families for the Department's coordinated health program which includes enrollment in health maintenance organizations;

   o providing information on family planning and making referrals to family planning agencies;

   o assisting clients in obtaining Medicaid benefits;

   o participating in the recruitment of medical care providers to PGH.

5. In order to facilitate communications between PGH field workers and other local office workers, the Commissioner should consider two options:

   Option 1: Making the Division of Eligibility Operations responsible for the daily supervision of the PGH field staff, thereby integrating the PGH workers fully into the field office structure.

   Option 2: Maintaining the current supervisory structure and increasing the responsibility of local office eligibility workers for referrals to PGH by setting standards for the completeness, accuracy, and timeliness of referrals.

CHAPTER I

INTRODUCTION

In 1967 Congress amended the Medicaid law to include preventive care as well as treatment services for children under 21. The amendment requires every state to establish an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for Medicaid eligible children. Massachusetts began its EPSDT program, known as Project Good Health (PGH), in 1972.

All clients who receive AFDC and those with children under 21 who receive only Medicaid are eligible for PGH services. As a Medicaid program, EPSDT requires states to pay doctor's bills for participants in the program. EPSDT, however, goes beyond Medicaid in also requiring states to ensure the availability of services to children whose families choose to participate.

CONTINUING ENROLLMENT ISSUES

As of July 1984, 55,573 children, or 26 percent of the eligible population of Medicaid recipients under age 21, were participating in PGH.[1] Although the proportion of eligible children enrolled in PGH is lower than the goal of 50 percent set for Fiscal Year 1985, 26 percent represents a substantial increase in program participation. In 1980, the plaintiffs in Vega v. Moran, a class action suit brought against the Department for failure to administer PGH properly, charged that only 6 percent of the total eligible population was participating. A 1977 publication of the Children's Defense Fund ranked Massachusetts 48th among the states in numbers of screenings provided per eligible child.[2]

Increasing the enrollment in PGH is a priority goal for the Department of Public Welfare in 1985. Currently in Massachusetts there are approximately 215,000 Medicaid recipients under the age of 21, all of whom are eligible for preventive health care on a regular basis under PGH. Nearly four-fifths of these children (79 percent) are from families receiving AFDC, 17 percent are eligible for Medicaid only, 3 percent receive SSI (Supplemental Security Income for disabled persons) and 2 percent are from families who receive refugee assistance.

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[1]The Federal Department of Health and Human Services (HHS) administers the Medicaid program. It measures states' participation in EPSDT by the number of screenings per eligible population. For Federal Fiscal Year 1984, HHS reported that nationally the number of screenings represented 25 percent of the eligible population. In Massachusetts, the participation rate calculated in the same way was slightly higher at 29 percent.

[2]Children's Defense Fund, EPSDT: Does It Spell Health Care for Children, Washington, D.C., June 1977.

In addition to providing for quality preventive health care, EPSDT has been shown to affect the incidence of subsequent illness and thereby reduce overall Medicaid expenses. A study of the effects of the EPSDT program in Michigan, for example, found that the Medicaid costs of children participating in EPSDT were 13 percent lower than the Medicaid costs of non-participants, not including the cost of the EPSDT program. When the EPSDT costs were included, costs for participants were still 7 percent lower than for nonparticipants. Expansion of enrollment in PGH thus has the potential not only to benefit many children in the Commonwealth, but also to be cost-effective.[3]

FEDERAL REQUIREMENTS

Provider Participation

Only medical providers who participate in Medicaid and who offer primary care services (such as general practitioners, family practitioners, pediatricians, internists, and gynecologists) can provide PGH services. Providers who offer PGH services must fill out a separate billing form and keep certain types of records on the PGH patients they see. Currently, the majority of Medicaid primary care providers do not offer PGH services.

Until very recently, continuing care providers such as health maintenance organizations could not easily participate in PGH. New Federal regulations effective January 29, 1985, allow children enrolled with a continuing care provider to participate in PGH and require only summary reports on PGH services, rather than individual reports and billing for each child.

Screening Services

Federal regulations stipulate that an EPSDT screen should include a physical examination and health history, immunizations, developmental assessment, nutritional status assessment, hearing and vision tests, laboratory tests, and counseling if necessary. The regulations give the states discretion in developing the detailed protocol and periodicity schedules of tests to be given. These must meet "reasonable standards of medical and dental practice" and must specify "the screening services applicable at each stage of a recipient's life."

In Massachusetts, the protocol and the schedule of screenings were developed in conjunction with the Massachusetts Chapter of the American Academy of Pediatrics. Under these guidelines, six screenings are given to a child before he or she is a year old, three screenings are provided in the second year, two in the third year, one each year from the age of three to the age of nine, and one every other year from age ten to age twenty. A copy of the full

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[3]William J. Keller, Ph.D., "Study of Selected Outcome of the Early and Periodic Screening, Diagnosis, and Treatment Program in Michigan," Public Health Reports, Vol. 98, No. #2, March-April 1983. Other studies in Ohio and North Carolina report similar findings; these are described in the 1983 report of the Health Care Finance Administration Bureau of Program Operations.

periodicity schedule is included in Appendix A. Both the protocol and periodicity schedule exceed the required Federal standards. They also exceed the schedules used in many other states. (See Appendix B.)

Federal regulations also require states to provide the services found necessary by the screening. The services include those covered in the state plan for Medicaid. Vision, hearing and dental services are covered even if they are not included in the state plan.

Procedures for Informing Clients

The Federal regulations also set detailed requirements for the way in which eligible families are informed about the program. Because participation in PGH is completely voluntary, informing eligible families of the availability of PGH services is an important aspect of the program.

Until very recent changes in the Federal regulations, AFDC families had to be informed about PGH services in person and in writing within 60 days of being determined eligible for Medicaid. Once a year, all eligible families had to be informed of the program in writing. The Federal regulations also set standards for the type of materials used to inform families and the contents of these materials.

The regulations effective January 29, 1985 broaden the states' discretion in informing families. Instead of specifically setting out the form and content of the information, the regulations require states to "effectively inform" eligible families. However, the more stringent Vega stipulation described below will, unless changed, continue to govern PGH practices.

Vega v. Moran

In Massachusetts, the operation of PGH is governed not only by Federal regulation, but also by a 1978 court stipulation which is stricter than Federal requirements. The stipulation resulted from a lawsuit brought against the Department of Public Welfare in 1974. In Vega v. Moran, a class of plaintiffs stated that the Department had "persistently failed to establish and administer fully and properly an EPDST program in Massachusetts."

The stipulation, which is still in force, committed the Department to increase the number of PGH enrollees and providers. It set specific requirements and implementation deadlines for outreach procedures, provider particpation, protocol, screening, follow-up treatment and reporting.

Program Structure and Costs

In August 1984, PGH had a total staff of 71: 14 in the Department of Public Welfare's Central Office and 57 in the field. The annual cost of the program is roughly $1.7 million. The PGH line item appropriation for Fiscal Year 1985 is $1.15 million, which covers the salaries of all field staff and a few Central Office staff. Other Central Office staff salaries, totaling approximately $255,000, are paid from the Department's general administration account. Printing and postage costs for the program are also paid from a general administration account. In FY84, these expenditures totaled

approximately $264,000.

The PGH program is managed and administered from the Department's Central Office by a staff which has responsibility both for administration, oversight and training of the field staff, and recruitment of health providers. For the past two years, recruitment of providers to participate in PGH has been given little emphasis in the PGH program structure. In contrast to the large field staff, only one staff member has been responsible for provider relations and recruitment. Almost all recruitment efforts have been directed to individual physicians, primarily pediatricians. Recently, three new people have been hired to assist with provider recruitment.

PGH field staff includes 32 specialists, 19 technicians, and 6 supervisors who are located in local welfare offices. To ensure coverage of all local offices, some field workers divide their time among offices; each of the supervisors has responsibility for staff in several offices. The field staff is responsible for enrollment and client assistance.

Client Access to PGH Services

Clients can enter the PGH program in two ways:

- o through a PGH provider; or
- o through assistance by a PGH worker.

Clients can become PGH recipients directly through PGH providers: if their regular health care providers use the PGH protocol and bill for services on the PGH claim forms, the children receiving the screenings are enrolled in PGH. The clients need not have any contact with the PGH workers in the local offices.

Clients can enter the program through the PGH worker by being referred by a worker to a PGH provider or by receiving other assistance from a worker in obtaining health care.

When a client applies for AFDC or Medicaid, the worker conducting the interview describes Project Good Health and hands out an introductory brochure. The AFDC application asks for a list of all children under 21, with information as to whether they receive regular medical and dental care, are up to date on immunizations, and have any special health problems. The applicant is also asked whether she is interested in more information about PGH. The application for Medicaid-only asks similar health care questions for those under 21.

Upon determination of client eligibility, the PGH field worker responsible for that welfare office receives a copy of the PGH sections of the application. Within specified time periods determined by the health status of the children under 21, the specialist or technician sends all eligible families a letter and brochures informing them about the program. The field staff follow up with telephone calls or office or home visits, with priority given to families who request help or whose applications indicate a lack of regular medical care or special medical problems.

In contacting families, the PGH field staff provide information on the

importance of preventive health care and assistance in choosing a medical and dental care provider. Upon request from the client, they can help with scheduling appointments and arranging for transportation and child care. With PGH staff help, the client chooses a provider, makes an appointment, and arranges for further treatment. It is the client's responsibility to keep all appointments.

CONTENTS OF THE REPORT

This report presents findings and recommendations from an evaluation of PGH conducted by the Office of Research, Planning and Evaluation of the Department of Public Welfare. Major data collection took place between March and August 1984. The analysis has focused particularly on identifying problems in current enrollment strategies and developing recommendations as to how enrollment could be increased. The report also delineates the programmatic and administrative changes necessary to pursue alternative enrollment strategies. The remainder of the report is organized in five chapters.

- Chapter II examines current PGH enrollment strategies and identifies limitations of these strategies, especially in relation to populations that are disproportionately underenrolled in PGH.

- Chapter III examines provider participation in PGH, and considers the strategy of provider recruitment as a means both of reaching families with regular medical care and of providing a large pool of PGH providers for families lacking adequate health care arrangements.

- Chapter IV identifies key agencies and institutions that are in touch with eligible families and through which Project Good Health might reach these families.

- Chapter V deals with the role of PGH field staff and suggests a refocusing and redefinition in order to meet the high priority goal of increased enrollment in PGH.

- Chapter VI explores the possibility of PGH staff, as part of their redefined role, offering family planning services to teenage clients of the Welfare Department.

CHAPTER II

CURRENT ENROLLMENT STRATEGIES

Eligible families gain access to PGH services either through the assistance of PGH field workers or through health care providers who participate in PGH. Current enrollment strategies emphasize the outreach efforts of PGH specialists and technicians in local welfare offices. In large measure, this emphasis has been dictated by Federal EPSDT regulations and by the court stipulation resulting from Vega v. Moran. EPSDT is a voluntary program. Therefore, the Federal and court strategies for maximizing the number of families who receive PGH screens focus on extensive procedures for notifying eligible clients of the availability of PGH services.

The mandated procedures, however, have not been successful in bringing the majority of families into PGH. Only 26 percent of the eligible population of AFDC and Medicaid clients under 21 receive PGH services. Among certain groups of eligible clients, the underenrollment is even more extreme. Current enrollment strategies have been particularly unsuccessful in reaching adolescents, families whose members do not speak English or are recent immigrants, and children in the care and custody of state agencies.

The development of effective strategies to increase enrollment requires an examination of the limitations of the enrollment strategies currently in use, especially in relation to those populations that have been disproportionately underrepresented. This chapter reviews current enrollment strategies and identifies major barriers to client enrollment.

ISSUES AND FINDINGS

A. Barriers to Client Enrollment

The evaluation staff examined and assessed the effectiveness of current enrollment strategies through reviewing PGH program statistics and program reports, and conducting worker, client, and physician surveys. This section summarizes the major findings.

1. Field worker efforts account for about one quarter of the PGH enrollment.

   a. PGH program statistics indicate that 27 percent of participants are enrolled through contact with a PGH field worker. The rest are enrolled because they happen to go to a Medicaid provider who offers PGH services.

      As noted earlier, approximately 26 percent of eligible children participate in PGH. If providers enroll about three-quarters of these participants, then the efforts of field staff result in the enrollment of only about 7 percent of the eligible population.

b. An analysis of PGH enrollment by geographic area shows that client participation is not correlated with the number of PGH workers in each local office or the size of their potential caseloads. (These data are shown in Table V-1).

   The only factor which is statistically correlated with participation among eligible children is the percentage of Medicaid providers in each area who offer PGH services.

2. The field workers' current activities have a low payoff in enrolling clients in PGH.

   a. A written survey of PGH workers conducted by the evaluation staff in August 1984 indicates that specialists and technicians spend between 22 and 24 hours per week sending letters and making telephone calls to eligible families, as dictated by Federal regulations and the court stipulation. (For more description of this survey, see Appendix C.)

      Using the workers' estimates of the number of families who are assisted each week in finding medical care as a result of these activities, it appears that specialists enroll .4 families per hour spent sending letters and .7 families per hour spent making telephone calls; technicians show a similar pattern. (The results of the worker survey and the way in which the PGH field staff spend their time are discussed in more detail in Chapter V.)

   b. In a telephone survey of 400 PGH-eligible families conducted in May 1984, 74 percent of the respondents reported that they had heard of Project Good Health. (See Table II-1; for a complete description of the survey, see Appendix D.) In spite of the large proportion of eligible families who had heard of PGH, however, only 19 percent reported having received PGH services.

      Survey respondents had most often heard about PGH through a letter from the program (46 percent of respondents). (See Table II-2.) This indicates that the practice of sending letters and brochures about the program to all newly eligible families does serve to inform people about PGH, but that letters alone do not result in enrollment.

   c. In the summer of 1984, PGH sponsored an intensive outreach project in four geographic areas. (See Appendix E.) Instead of contacting newly eligible clients, which is the present practice, the project staff attempted to contact all clients by telephone. The results from this project with the range of results in different offices are summarized below:

      - They were able to reach and speak to between 32 and 34 percent of eligible families;

Table II-1

PGH KNOWLEDGE V. ENROLLMENT

Geographic Region	Percent who've heard of PGH	Percent Enrolled*
Boston	60%	3%
Springfield	83	24
Worcester	77	20
Lawrence	68	22
Greater Boston	83	17
New Bedford	81	31
Total	74	20

*Department records, not survey data

Table II-2

HOW HEARD ABOUT PGH
(N=290)

Letter from PGH	46%
Welfare caseworker	24
Other	16
Brochure	14
PGH worker	6
Friend/relative/acquaintance	5
Doctor or doctor's office	5
Day care or head start center	3
Newspaper/radio/television	3
DK/NA	1

- In a high percentage of cases -- 18 percent in one area -- a family was reached but the caller could not speak the client's language;

- Between 17 and 27 percent of the families either had no phones or the phones were disconnected;

- In 14 to 35 percent of the cases, there was no answer or a message left was not returned.

- Of all of the families reached by phone, between 13 and 24 percent were assisted. This was 4-8 percent of the number of families originally targeted -- or about the same percentage as PGH workers customarily enroll.

3. A substantial portion of the eligible families not participating in PGH already have regular well-child medical and dental care.

   a. In the telephone survey of PGH-eligible families, the majority of respondents reported that they took their children to the doctor for routine well-child care:

      - 92 percent of the parents of childen under six reported taking their children for routine care;

      - 80 percent of the parents of children 6 to 14 took their children; and

      - 59 percent of the parents of children 15 and older provided routine care.

   b. Findings from the intensive outreach project also indicate that the majority of those eligible receive regular medical and dental care. Attempts to contact all new and ongoing PGH-eligible families in four areas found that:

      - 86 percent of those contacted reported they were already receiving regular medical care and

      - 74 percent reported they were already receiving routine dental care.

   c. Data from a register of PGH field worker referrals in selected local offices show that approximately 45 percent of the newly eligible clients reported having regular medical and dental care.

4. The majority of Medicaid physicians do not participate in PGH.

   a. According to Department statistics, 357 Medicaid pediatricians provided PGH services as of November 1984. Statewide this represented 44 percent of the 815 Medicaid pediatricians.

According to PGH staff, these percentages are close to the maximum eligible to participate in PGH. Many of the rest of the Medicaid pediatricians are out of state, hospital-based, or specialize in one aspect of pediatric care and therefore are not really primary care providers.

Many pediatricians in the state do accept Medicaid patients. According to Folio's Medical Directory of Massachusetts (1984), there are 1172 pediatricians in the state. Thus, the 815 Medicaid pediatricians represent 70 percent of all pediatricians in the state.

b. The proportion of other primary care physicians who participate is lower. As of November 1984, 86 general and family practitioners and 43 internists participated in PGH. This represents 10 percent of all Medicaid general/family practitioners and 2 percent of all Medicaid internists statewide.

c. There is wide range in the proportion of Medicaid primary care physicians who offer PGH services in different parts of the state. As of August 1983, the proportion of pediatricians and general or family practitioners in PGH ranged from 6 percent in Boston to 27 percent in Springfield. (See Table II-3.)

No analysis is available of the distribution of physicians offering PGH services since August 1983. Other information, however, shows that the total number of physicians offering PGH services in the state as a whole has greatly increased since then. Between June and November 1984 alone, PGH staff estimate that 106 new physicians joined the program.

5. Many families do not use individual physicians as their regular source of medical care.

a. In the telephone survey of PGH eligible families, people were asked where they usually go for health care. Their responses indicated that:

° 57 percent go to a private physician;

° 23 percent go to a community health center;

° 18 percent go to a hospital clinic. (See Table II-4.)

Even among families who reported taking their children regularly for routine well-child care, many said that they use community health centers (23 percent) or hospital clinics (15 percent).

b. According to the survey, the use of different sources of medical care varies among areas of the state:

° In Boston, for example, only 15 percent of the respondents use private physicians while 47 percent use community health centers and 33 percent use hospital clinics.

Table II-3

PROVIDER PARTICIPATION IN PGH

Geographic Region	Percent of Medicaid Providers Participating in PGH*
Springfield	27
Worcester	15
Lawrence	23
Greater Boston	22
New Bedford	26
Boston	6

*Medicaid providers include only pediatricians and family practitioners in this analysis

Source: "Physicians Providing PGH Health Assessments" report; data from August 1983, and MMIS report listing Medicaid providers, May 1984.

Table II-4

USUAL SOURCE OF CARE

Geographic Region	Private Doctor	CHC	Hospital Emergency	Hospital Clinic	Other
Boston	15%	47%	12%	33%	12%
Springfield	71	17	8	12	5
Worcester	59	25	9	16	7
Lawrence	67	19	15	14	6
Greater Boston	67	15	5	20	0
New Bedford	73	10	4	13	12
Total	57	23	9	18	7

° In contrast, in New Bedford 73 percent of the respondents use private physicians. (See Table II-5).

c. Overall PGH enrollment is correlated with the percent of Medicaid physicians enrolled in PGH in different areas of the state. However, as the scatter plot in Table II-6 shows, the relationship is stronger at the lower end of the scale than at the upper end. This pattern suggests that low physician participation will inhibit enrollment, but high physician participation will not necessarily guarantee high enrollment in PGH.

6. PGH enrollment in different parts of the state correlates with the proportion of families who usually go to individual physicians for medical care.

Linking Department enrollment statistics with telephone survey data on families' source of medical care shows, for example, that:

° In the Boston area, where a low proportion of the respondents use private physicians, the PGH enrollment is the lowest in the state -- only 5 percent of the eligible children.

° In the New Bedford area, where almost three-quarters of the eligible children use private physicians, the PGH enrollment is 40 percent of eligible children (See Table II-5).

B. Populations Disproportionately Underenrolled in PGH

Some families or individuals face special barriers to their participation in PGH. This section of the chapter discusses several groups that are particularly underenrolled in PGH.

1. The adolescent population has the lowest participation of any age group.

a. In September, 1981, 19 percent of eligibles aged 13 through 17 participated in PGH, compared to 26 percent for all age groups. Of the 18 through 20-year-old-group, only 11 percent participated during the same time period.

b. The low rate of participation by adolescents in PGH is consistent with the low rate at which adolescents utilize preventive health in general. According to a report done in 1981, by the Select Panel for the Promotion of Child Health of the Federal Department of Health and Human Services, teenagers usually seek health care only when they are ill, injured, or for a specific purpose, such as family planning.

Table II-5

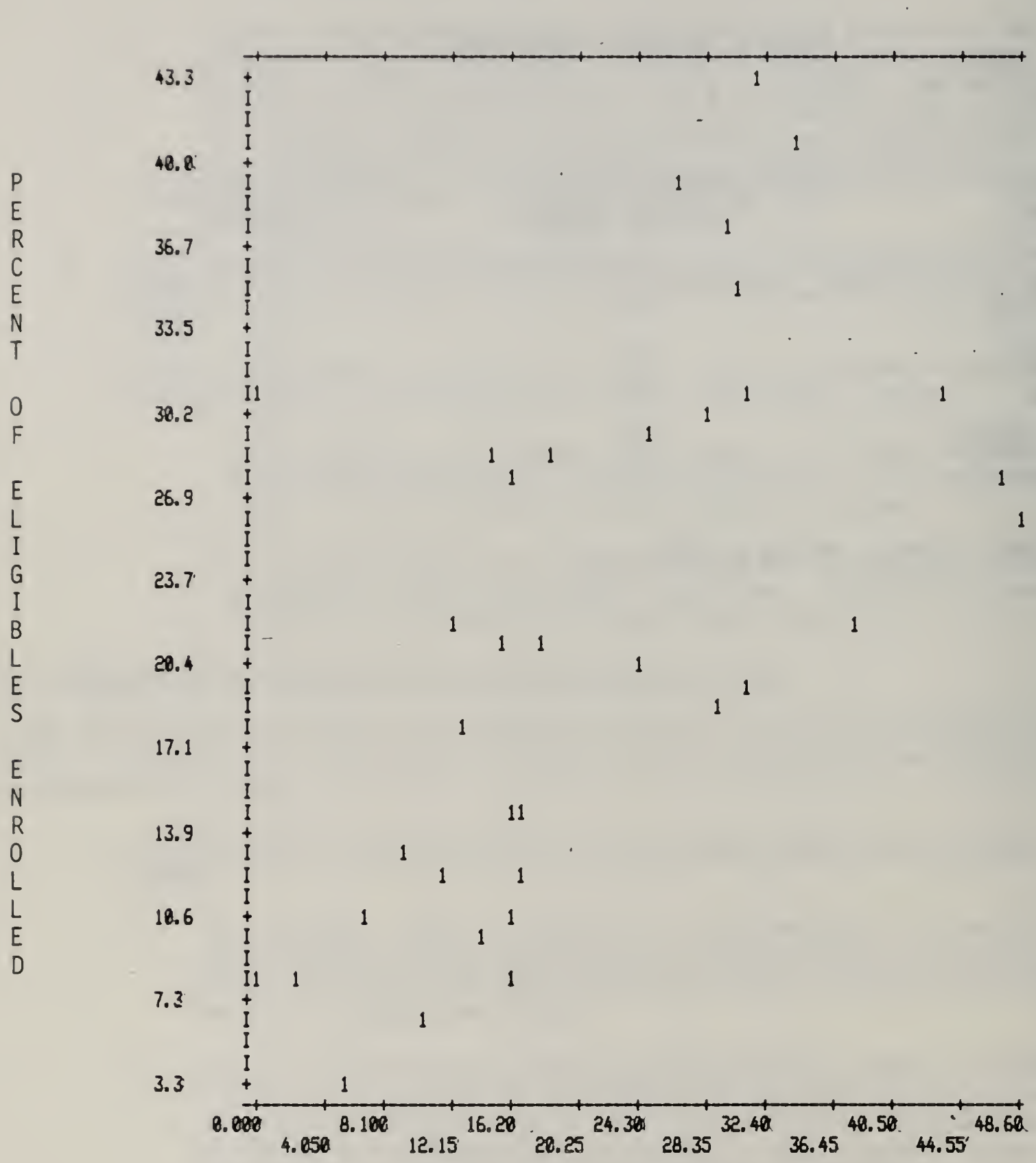
PRIVATE DOCTOR V. ENROLLMENT

Georgraphic Region	Percent using a private doctor	Percent Enrolled in PGH*
Boston	15%	3%
Springfield	71	24
Worcester	59	20
Lawrence	67	22
Greater Boston	67	17
New Bedford	73	31

*Department records, not surey data

Table II-6

PERCENT ENROLLED PLOTTED BY PERCENT OF PROVIDERS PARTICIPATING IN PGH
IN EACH LOCAL WELFARE SERVICE AREA



c. The Welfare Department survey of families eligible for PGH also found that adolescents were the age group which reported the lowest proportion receiving regular health care. Ninety-two percent of the survey respondents with children under 6 reported that they received well-child medical care, and 80 percent of the families with children 6 to 14 reported that they received this type of care. For adolescents, however, the figure was much lower--59 percent of respondents with children 15 to 20 reported that they received regular medical care.

d. According to PGH field workers, many pediatricians see mostly younger children, making it difficult to attract adolescents who feel uncomfortable being treated by a "children's" physician. Some pediatricians make a special effort to tailor their services for adolescents, but there are not enough of these pediatricians in PGH to serve the eligible adolescents.

2. <u>PGH has had limited success in reaching the significant proportion of eligible families who do not speak English.</u>

a. In the summer of 1983, the Employment and Training program asked all AFDC recipients whose cases were redetermined in July to complete brief questionnaires on their backgrounds and support service needs. The results of this statewide survey indicate that 13 percent of the AFDC caseload does not speak English. This means that roughly 28,000 children eligible for PGH are from non-English speaking families.

b. In the PGH intensive outreach project mentioned earlier, in 18 percent of the cases in one area, a family was reached by telephone but the call could not be completed because no one at home spoke English.

c. Federal regulations and the <u>Vega</u> stipulation both require PGH to set up procedures to reach non-English speaking families. The PGH field staff includes seven workers who speak Spanish and Portuguese as well as English. These are the only workers who speak a language other than English. The other PGH field workers must ask non-English speaking persons to find a translator before the worker can answer their questions. PGH informational brochures are available in eleven languauges; specific materials on preventive health needs for children of different ages are available in four languages.

d. Recent immigrants, expecially those from Southeast Asia, face cultural barriers to participation in PGH. According to Department of Public Health staff who work with Southeast Asians in the Program for Women, Infants and Children (WIC), these families find the American medical system confusing and frightening, and preventive health care particularly unfamiliar.

WIC staff also report that many recent immigrants are under great personal and financial stress that reduces their interest in less immediate needs like preventive health care.

3. Children in the custody of state agencies tend to have existing health problems and to lack a history of routine, preventive health care.

   a. A number of state agencies are involved in the care and custody of children. The Department of Social Services, the Department of Youth Services, and the Department of Mental Health are responsible for over 13,000 children under 21 who are eligible for PGH services. The largest number of affected children are in the care of the Department of Social Services. Very few of these children, however, are actually enrolled in PGH.

   b. The Department of Social Services estimates that as many as 30 percent of the children in their care and custody have physical handicaps, and another 30 to 40 percent have emotional handicaps. A study of dental health problems of children in the care of the Department of Youth Services found that the average 15 year old male in a secure or detention facility had a total of 8.7 teeth affected by decay, 36 percent higher than the statewide average.

IMPLICATIONS

The enrollment strategies currently used in Project Good Health have serious limitations which undermine the Department's ability to increase the proportion of eligible families receiving PGH services. The findings presented in this chapter suggest that these limitations will not be corrected simply by intensifying current enrollment activities. Rather, there is the need to redefine the specific activities and to develop a substantially different approach.

The current enrollment procedures do not address, and in some instances may even exacerbate, the major barriers to client enrollment. The evidence points to a continuing low success rate for outreach efforts based mainly on telephone calls and letters to eligible families.

The majority of eligible families have regular sources of medical care outside of PGH. With no tangible incentives offered by PGH, they are unlikely to change to a PGH provider, particularly if the PGH provider is less accessible to them. They are most likely to be brought into PGH through the recruitment of their regular health care provider. As the findings indicate, three-fourths of the current PGH enrollment originates with providers.

Until recently, however, few resources have been devoted to recruitment of providers and the pool of providers has been limited by EPSDT requirements. The vast majority of current PGH providers are individual physicians, predominantly pediatricians. But close to half of the PGH eligible families statewide, and a higher proportion in some areas, get their medical care from other types of providers such as community health centers.

The current emphasis on letters and phone calls is even more problematic in the recruitment of families who do not have a regular source of medical care. Establishing an adequate pool of providers to serve families in need of care is critical, but will not by itself increase enrollment. More active and targeted outreach methods are needed, particularly to reach adolescents and non-English speaking families, two of the groups currently most underrepresented in PGH.

For families whose members do not speak English or who are recent immigrants, cultural and language barriers limit their access to PGH. These families may be from countries where health care is provided differently; their limited contact with a PGH worker, particularly if the worker does not speak their language, may not help them understand what services are offered or what preventive medical care involves.

Adolescents also present special problems. Even in families where other members receive routine health care, adolescents tend not to seek health care. They are especially unlikely to go to pediatricians, who constitute the largest group of physicians participating in PGH.

Bringing these families and individuals into PGH will require both persuasion that preventive health care is worthwhile and assistance in locating health care. They are most likely to become enrolled in PGH through agencies, institutions, and private organizations that are easily accessible to them and with which they already have regular contact or through more personal, in-person contact with PGH field staff.

The evidence points to the need to direct different enrollment strategies to those families who already have regular medical care and those who do not. In both cases the basic approach is to reach families through existing channels. The following three chapters explore the potential of reaching families through the health care providers they already see or to whom they have access; and of reaching those families without any medical care or medical access through an expanded service delivery and recruitment system that includes government agencies and private organizations which are already accessible to and in touch with the target populations, as well as through PGH field staff with a refocused set of activities.

CHAPTER III

PROVIDER RECRUITMENT

The recruitment of health care providers into PGH has received far less attention than the recruitment of clients. The field staff responsible for recruiting clients has numbered more than 50 while, until recently, only one person handled both provider recruitment and ongoing relations with PGH providers. Most of the recruitment efforts have been directed to individual physicians, predominantly pediatricians. Because the recruitment efforts have been so limited, however, the majority of physicians who accept Medicaid do not participate in PGH. The availability of PGH pediatricians varies substantially among parts of the state, and other types of providers commonly used by PGH eligible families, with few exceptions, do not participate in PGH.

This chapter examines problems in the current structure for provider recruitment and in the current strategies for attracting and retaining individual physicians who are PGH providers. The chapter also identifies and explores issues that must be addressed to expand the pool of participating providers and facilitate the participation of other kinds of health care providers.

ISSUES AND FINDINGS

A. Provider Recruitment Structure

Potential PGH providers are identified in two ways. First, the Central Office PGH staff member responsible for provider recruitment reviews Medicaid claims, targeting those providers who submit large claims and thus probably serve large numbers of Medicaid recipients. Second, PGH staff in local offices send questionnaires once a year to all primary care providers in their area to determine which providers accept Medicaid and might be interested in providing PGH services. Positive responses are sent to Central Office for follow up.

Recruitment is done on a one-to-one basis. Physicians identified as potential providers are contacted with a letter and brochure explaining the program. The provider recruitment staff member calls the potential providers to arrange to visit their offices. This recruitment structure has several limitations which are described below. The recent addition of three new provider recruitment staff in PGH is intended to address these limitations.

1. PGH has never implemented a comprehensive marketing strategy.

   a. In 1981, the Federal Department of Health and Human Services contracted with the Community Health Foundation to review PGH activities for marketing the program to health care providers. The Foundation concluded that:

      - PGH provider recruitment was not very successful;
      - PGH staff confused recruitment efforts with efforts to train providers on forms and procedures;
      - The 250 page physician manual was not an effective means of recruiting physicians;
      - Physicians were being approached as if they were all alike;
      - PGH recruitment was hampered by the programatic failure to modify forms or procedures in response to physicians' suggestions.
      - A retention program for PGH physicians should be emphasized. As the Foundation stated: "It is generally much less difficult and expensive to keep physicians interested than it is to convince them to participate in the first place."

      When the study was completed in 1982, the Foundation outlined a marketing plan for PGH. As a result, PGH instituted minor changes, e.g., in the PGH claim form. But, a comprehensive marketing strategy was never implemented. According to PGH staff members, there were not enough staff or resources to carry out the recommendations nor was there commitment from the administration at that time.

   b. In August 1984, the Medicaid Coordinated Health Programs Unit developed a marketing plan for PGH and the Health Connection. The plan laid out marketing goals and objectives and listed tasks and timetables for accomplishing the objectives. However, the plan did not include several crucial items: an analysis of the major issues the program faces in trying to meet its enrollment goals, an explanation of how the planned activities fit with current marketing efforts, and a description of what the proposed strategies involve.

2. During the past year, the provider recruitment staff member spent most of her time helping current PGH providers with Medicaid claims problems.

   The provider recruitment staff member has regularly handled complaints and claims processing problems for physicians participating in PGH. This last year, these responsibilities expanded dramatically when the implementation of the Medicaid Management Information System (MMIS) caused major problems in paying providers.

3. PGH field workers, who have regular if limited contact with the Medicaid providers in their area, have not been used to recruit new providers.

In the survey of field workers, respondents reported an average of 2 or 3 contacts with providers per week. The most frequent reasons for making contacts with providers were to make appointments for clients or to answer questions about PGH.

Yet, PGH field workers have no formal role in recruitment beyond sending questionnaires to the primary care providers in their area each year. Although the workers informally report on potential new providers, all follow-up on positive responses is done by Central Office staff.

B. Recruitment of Individual Physicians

As noted in Chapter II, the majority of physicians who accept Medicaid patients do not participate in PGH. Participation is highest among pediatricians; it is much lower among other primary care physicians, such as general or family practitioners or internists. Moreover, participation by individual physicians is unevenly distributed across the state. This means that PGH-eligible families in some parts of the state are very unlikely to have access to PGH providers.

In order to find out why more physicians do not offer PGH services, the evaluation staff conducted interviews with fourteen pediatricians in May and June 1984 (See Appendix F). All were physicians participating in Medicaid; ten offered PGH services, and four did not. Among those interviewed was at least one physician from each geographic region of the state. Pediatricians were selected who would be aware of the views of other physicians in their communities. Chosen with assistance from the Massachusetts Chapter of the American Academy of Pediatrics, they tended to be established members of the profession, who had been in practice for a fairly long period of time.

This section, drawn largely from the interview data, addresses the problem and issues that reportedly discourage primary care physicians from becoming PGH providers. Suggestions made by physicians for recruitment strategies are also included.

1. The specific aspects of PGH most often labeled as problems were audits and billing and payment practices; in many cases the physicians interviewed felt these problems kept other physicians from joining PGH.

   a. Audits. Audits are more of a problem for PGH physicians than for other Medicaid physicians. Unlike most Medicaid services, the PGH protocol includes specific tests and assessments that the physician must provide in order to be reimbursed the additional amount for a PGH screen. Thus, to justify this additional reimbursement, the PGH physician is required to provide more documentation for PGH services than for other types of Medicaid services. Many of the PGH physicians felt that they had not been adequately informed when they began providing PGH services of the extent of the required documentation.

Even those physicians who had not been audited had heard enough from their colleagues to cause them to have strong feelings about the process.

The physicians interviewed also had a number of suggestions with respect to the audit process. These included:

- Establishing a working group of physicians and state auditors to delineate explicit standards and procedures for audits;
- Offering to have PGH staff review physicians' records to inform them about weaknesses in their PGH recordkeeping practices before they were audited;
- Establishing more explicit documentation standards.

b. Billing and payment practices. PGH physicians saw slow payments as a significant problem. In addition to recent problems with the new Medicaid Management Information System (MMIS), nearly all the physicians complained of chronic difficulties in timely reimbursement. One physician interviewed reported that he usually carries several thousand dollars in overdue Medicaid payments on his books.

Another major problem is the amount of time required of both the physician and the billing clerk to complete the PGH forms. One physician reported that, although PGH participants make up only about one-fifth of his patients, nearly all of his bookkeeper's time is taken up with PGH and Medicaid problems. Several physicians mentioned that the amount of paperwork involved in PGH makes it much more expensive for them to give a PGH examination than a regular well-child examination.

Other related issues the PGH physicians mentioned were requests for payment being denied, and having to wait up to 30 days for test results before a billing form could be submitted.

One physician reported that his clerk had discarded information on PGH without showing it to him because she felt that Medicaid was more trouble than it was worth and she did not want any more involvement with the program.

c. Additional comments. One PGH physician expressed concern about the monitoring of children with health problems by PGH. He felt that the existing system was inadequate and that this placed an additional responsibility on the physician.

When asked about changes in the program that might attract more physicians, three PGH physicians mentioned better training and orientation of both new PGH physicians and their staffs. One felt that the provider manual should be simplified and made easier to use.

2. Many of the physicians interviewed had problems with the communications between health care providers and PGH and Medicaid staff.

   a. The PGH physicians described communication problems both in the provision of information to them and in the willingness of PGH to accept suggestions.

      Four of the PGH physicians stated that they had experienced serious difficulties obtaining assistance from Medicaid or from Systems Development Corporation (SDC), the contractor who operates the MMIS system. At the time of the interviews, the physicians and their billing clerks reported problems both in reaching Medicaid and SDC by telephone and in finding someone to answer their questions once they got through. One physician's billing clerk also said she had been told to "look it up in the manual" when she requested information from Medicaid.

      When asked why other Medicaid physicians do not offer PGH services, two of the PGH physicians mentioned the lack of response by PGH to their comments and suggestions. Other physicians spoke in general of unresponsive bureaucracies or what they felt was a general distrust of physicians by Medicaid staff.

   b. The poor communications between PGH and the physicians is underscored by the report from PGH staff that some of the suggestions made by physicians in the interviews had already been implemented by PGH. For example, one physician asked that he not be required to repeat vision and hearing tests done in schools. In fact, the PGH protocol does not require that tests done in schools be repeated.

   c. Several physicians had suggestions for improving communication between themselves and PGH. These included:

      - Establishing an advisory committee of physicians to assist PGH with medical issues;
      - Including a physician employed as a medical advisor on the PGH staff;
      - Establishing a formal, ongoing link to the Massachusetts Chapter of the American Academy of Pediatrics.

3. PGH fees and screening protocol were not major issues among the physicians interviewed, but other health professionals felt that the nutritional status assessment portion of the protocol should be modified.

   a. Fees. Most of the physicians were satisfied with the fee of $40 for a PGH screen. Four of the PGH physicians said that the fee was adequate, and three felt it was more than adequate; only one physician felt it was inadequate. Another physician noted that his problem was with the timeliness, not the amount, of the fee.

b. Screening protocol. Generally, the physicians interviewed did not have major problems with the PGH protocol. Five of the ten PGH physicians felt that no changes were needed and that PGH physicians should be required to follow all the items in the protocol.

The other five physicians interviewed had suggestions for changes in the protocol. These included:

- Requiring annual examinations, even for adolescents.
- Eliminating repetition of tests already given in the schools, such as vision and hearing tests.
- Increasing the flexibility of the periodicity schedule to allow deviations in the ages at which examinations are given.
- Making specific changes in the tests given to children at certain ages.

PGH staff report that some of these changes have already been made. For example, annual examinations for adolescents are allowed and will be reimbursed, even though examinations are required for this age group only once every two years in the PGH periodicity schedule. As another example, described earlier, PGH providers do not have to repeat tests, such as vision and hearing screenings, already given in the schools.

c. Nutritional status assessment. Although the physicians interviewed did not mention problems with the nutritional status assessment portion of the screening protocol, some nutritionists felt the nutritional assessment was inadequate. Evidence from the 1983 Massachusetts Nutrition Survey done by the Department of Public Health has indicated that "chronic malnutrition is a significant public health problem in low-income preschool children in Massachusetts."

The regulations in the PGH physician manual for the nutritional status assessment are very general. They do not specify what tests are to be performed or what measures of nutritional status are to be used. The nutritionist who served on the PGH evaluation advisory committee suggested that the regulations be made more specific, and that children found to be at nutritional risk be referred to a nutritionist for diagnosis and treatment.

The difficulty with such a referral, according to PGH staff, is that services performed by a nutritionist are not reimbursed by Medicaid except when the nutritionist's services are part of the services of a larger unit such as a community health center. When such a reimbursement mechanism exists, however, the children could be referred to a nutritionist.

4. On average, the physicians who offered PGH services had a higher proportion of Medicaid patients than the physicians who did not.

   For the ten PGH physicians, the median proportion of their patients who had Medicaid coverage was 32.5 percent, with a range of 5 percent to 65 percent. The median for the four non-PGH physicians was 7.5 percent of their patients having Medicaid coverage, with a range of 5 percent to 15 percent.

5. The recruitment strategies emphasized by the physicians focus on personal and professional contacts.

   Among the ten physicians who participate in PGH, four had started offering PGH services because of an endorsement by the Massachusetts Chapter of the American Academy of Pediatrics or because of a recommendation by a colleague or business associate. In one of these cases, the recommendation came from the physician's billing service. Two of the physicians interviewed had been involved in setting up the PGH program, and one had begun offering PGH services when he was contacted by PGH recruitment staff.

   Two of the PGH physicians felt that many other Medicaid physicians simply did not know about the program. Another felt that other physicians might know about PGH but be unaware of recent changes in the program to simplify the paperwork.

   Specific recruitment strategies were suggested by most of the physicians interviewed. These included:

   - More visits by PGH recruitment staff and more contact from other other physicians.
   - Notices to physicians in Medicaid payments, or notices placed in professional journals or newsletters.
   - Informational programs sponsored by the Massachusetts Chapter of the American Academy of Pediatrics or the New England Pediatric Society.

C. Recruitment of Other Health Care Providers

The recruitment of a wider variety of health care providers into PGH would enable many more families to obtain PGH services. The families already using those providers would be able to obtain PGH services without changing to individual physicians. Families without stable health care arrangements could be more easily assisted and referred to an appropriate provider.

Three types of health care providers seem particularly promising candidates for PGH: community health centers, physicians at some hospital outpatient clinics, and health maintenance organizations. During the course of this study, the PGH staff have already begun to recruit some of these providers. This section describes the administrative, payment and regulatory issues which have hindered the participation of these providers in the past and discusses recent changes in those areas which facilitate participation. Remaining issues that must be addressed are identified.

1. Community health centers are able to provide PGH services at reasonable cost.

   a. There are approximately 30 independently licensed community health centers in the state which offer pediatric services; 15 are located in the Boston area. These community health centers already provide many of the screening services contained in the PGH protocol, as well as diagnosis and treatment for health problems discovered during screening.

   b. Until recently, few community health centers provided PGH services. In 1983 only five centers participated in PGH. According to the PGH staff and the centers themselves, the rate paid to the centers for PGH services was too low to make their participation worthwhile. The rate, set by the Rate Setting Commission, was $5.50 greater than each center's usual rate for a well-child visit. A PGH screening, however, requires more documentation and paperwork than a well-child visit, creating a financial disincentive for the centers to participate.

      Early in 1984, the rate for PGH services provided by community health centers was raised to $46 to cover the fee for a standard well-child visit. Since the increase in the fee, the PGH staff has recruited ten new centers to provide PGH services.

   c. The major remaining problems, according to some of the centers, involve the PGH documentation and reporting requirements. One community health center director, interviewed in April 1984, noted that the PGH requirements do not conform to the procedures already used by his center. According to PGH staff, many of these requirements are based on Federal Regulations or the Vega stipulation. He felt that PGH requirements were too intrusive and demonstrated a lack of trust in the community health centers. He mentioned specifically the requirements that providers wait for up to 30 days for the results of laboratory tests before billing PGH; that staff contact the welfare office when a PGH appointment is broken; that documentation be provided for efforts to persuade patients to take all the tests contained in the PGH protocol, and that physicians at the center document every test and assessment given.

2. Hospital outpatient departments and hospital-licensed health centers currently cannot bill for PGH services because of the way they keep patient records, document the services they provide and submit claims for reimbursement; some clinics are also very costly.

a. It has been suggested by a number of people, including the attorney for the plaintiffs in the Vega case, that PGH services should be provided by hospital outpatient clinics. She argues that the clinics are convenient to many children eligible for PGH and are able to provide the type of services PGH requires.

Currently, there are a number of factors which contribute to the difficulty in outpatient departments' participation in PGH:

Rates for Services. The rates paid by Medicaid for outpatient services are calculated on a hospital-by-hospital basis with each hospital submitting its charge book to the Rate Setting Commission (RSC). RSC sets the overall budget for each hospital, and the hospital then calculates its charges to meet that budget. Medicaid currently pays 100 percent of the hospital's outpatient charge; the percent paid for inpatient services is adjusted so that Medicaid pays approximately 70 percent of overall hospital charges.

Generally, outpatient department rates for well-child visits, particularly in Boston, are high in comparison to the current community health center rate of forty-six dollars. The rates for a well-child visit average between $50 and $100 and can be as high as the $285 paid to Boston City Hospital. Since participation in PGH would require more work by the outpatient department, the Welfare Department would be expected to pay a fee above the already high outpatient charge for a well-child visit. Without this increased fee, there is no incentive for outpatient departments to participate in PGH.

Recordkeeping and Documentation. Currently outpatient departments are not subject to any Medicaid regulations regarding records of patient visits or documenting services provided, although Medicaid will issue such regulations shortly. To date, the outpatient department system of recordkeeping and documentation has varied widely throughout the state. It is expected that some outpatient departments will have to adapt their procedures substantially in order to meet new Federal regulations that patient records include, among other things, the recipient's medical history, any tests administered and their results, and recommendations for addition treatments or consultations, when applicable.

In order for outpatient departments to participate in PGH, further revisions in their recordkeeping systems and possibly the services provided would need to be made. The PGH protocol would have to be followed and documentation to that effect would be required. Currently the components of a well-child visit vary depending upon the outpatient department.

Claim form. The outpatient departments would have to use a claim form which has been adapted for PGH purposes and possibly would need to establish a separate internal system for submitting such claims. The current standard outpatient department claim form identifies the patient's name, and asks for a description of the service provided, treatment authorized, and a description of the diagnoses.

The PGH claim form asks for further information including whether the patient is up-to-date on immunizations and whether the result of the PGH assessment indicates a need for further treatment. If so, documentation that a referral has been made is required. Additionally, the form asks whether every screen required by the PGH prototcol has been performed and, if not, the reasons for omissions. If there are outstanding lab tests, the PGH provider must hold the claim for 30 days and indicate for which tests results are still unknown, in order for PGH to monitor needed treatment.

b. Other states have used hospital outpatient departments as EPSDT providers. In Minnesota, outpatient departments bill for all services separately from the hospitals, so the outpatient charge does not include any of the hospital's overhead costs. The reimbursement rate for all EPSDT providers in the state is $65 for services provided by a physician, which is sufficient to induce outpatient departments to participate.

   In New York, the reimbursement rate for an EPSDT visit for both outpatient departments and community health centers ranges up to $65, depending on the location. This is the same rate outpatient departments are paid for a non-EPSDT well-child visit. Because outpatient departments had been dropping out of the EPSDT program, in April 1984 the state tried to reduce paperwork by allowing the outpatient departments to bill for EPSDT services on the same claim form used to bill for other Medicaid services. This billing form does not provide information on whether the child is up to date on screenings or whether all components of the protocol have been completed. As of December 1984, New York did not know whether this change had encouraged outpatient departments to stay in the program.

c. The situation is slightly different for hospital-licensed health centers. In general, the hospital-licensed health centers function as community health centers in regard to the types of services provided and the patient tracking systems used. They do, however, bill Medicaid through the hospital and the rates are determined in conjunction with the hospital.

   Like hospital-based outpatient departments, hospital-licensed health centers bill for their services on the outpatient department claim form and through a standard system used by the hospital.

3. Individual physicians who practice in outpatient departments, but are not salaried by the hospitals, are more likely than outpatient departments to be good candidates for PGH providers.

   a. At the present time, the PGH program is working to adapt the Medicaid Management Information System (MMIS) so that the claims by independent physicians who practice in outpatient departments will be accepted by the system. The PGH fee for their services is one-half of the regular PGH physician's fee because they are paid for their services but not the use of the facilities, which may be billed for by the hospitals. Once this modification is made by MMIS, the PGH program will be able to enroll physicians who serve PGH clients at outpatient department facilities.

      In recent months, PGH staff have identified two hospitals, Boston City Hospital and the University of Massachusetts, Worcester, where the physicians who practice in the outpatient department are not salaried by the hospital. Several physicians at both of these hospitals have expressed interest in becoming PGH providers once the MMIS system has been modified.

4. Many children enrolled with continuing care providers such as health maintenance organizations will become PGH participants when new Federal regulations are made final.

   a. Under the new Federal regulations, PGH can consider children enrolled with a continuing care provider as PGH participants, if the provider agrees to provide PGH services and to track the children to be sure needed screening and treatment services are received. Separate billings for PGH services will not be required but a summary report must be sent to the Department.

   b. Continuing care providers enrolled in the Health Connection, the Department's coordinated health program, in which providers including health maintenance organizations manage all the health care received by enrollees, have already agreed to provide PGH services. The children currently under their care can be enrolled as PGH participants as soon as they are identified.

      The number of children enrolled in PGH through continuing care providers will increase as the Department continues to enroll more families in the Health Connection. In October 1984, the Health Connection enrollment was 11,987; the goal for July 1985 is 25,000. Of these, PGH staff estimate that approximately 10,000 will be PGH-eligible children.

IMPLICATIONS

The findings in this chapter suggest ways that PGH provider recruitment efforts could be strengthened and restructured. With the addition of two new provider recruitment and relations staff, PGH has the resources to expand its recruitment efforts. In several areas, the staff has already started to take action.

First, PGH could use existing resources more effectively by formally integrating field staff into the recruitment process. In assisting PGH-eligible families, the specialists are particularly aware of the medical resources and the gaps in resources in their areas. They have personal contacts with providers. Their knowledge and personal network should be actively used to recruit new providers.

Second, the recruitment of individual physicians might be more successful if staff targeted their efforts to particular groups of physicians in different areas of the state. In most areas, PGH should try to recruit more general practitioners, family practitioners and internists. In those parts of the state where a relatively small proportion of Medicaid pediatricians participate, PGH staff should continue to recruit pediatricians as well. In areas where relatively few physicians participate in Medicaid, PGH staff should work with other Medicaid staff to recruit more Medicaid providers.

The findings from the evaluation study also suggest that the effectiveness of recruitment efforts could be increased by focusing less on offering information about PGH and more on responding to physicians' needs. PGH should consider the requests of the physicians interviewed for simplified procedures, additional training, and improved communication with the Department staff.

In large measure, these are areas of concern for ongoing provider relations as well. The retention of current providers is as important as the recruitment of new providers. One way to ensure that relations with current providers are not slighted may be to assign ongoing provider relations to a different member of the staff than the person doing provider recruitment.

The technical assistance that PGH has already begun to develop in the form of reviews of physicians' records has the potential to be an effective recruitment tool. The purpose of these reviews is to inform physicians about aspects of their recordkeeping that do not conform to requirements of the program, so that they can correct these problems and avoid future problems with formal audits. The record reviews, conducted by PGH staff, do not involve any penalties for physicians found to have made unintentional errors.

Third, more recruitment efforts should be directed to providers other than private physicians. Community health centers seem particularly promising. The recently increased payment rate to community health centers for PGH services removed an important obstacle to their participation.

Most health centers, however, still use forms and procedures which are different from those required by PGH. This problem could be addressed by PGH staff working with individual community health centers to minimize the burden on the center. Staff need to determine which of the center's procedures could be accommodated within the PGH system and develop ways to integrate the additional PGH requirements to the center's existing procedures. This approach would require more staff time than is presently spent recruiting a single provider, but would be cost-effective if a single community health center served large numbers of eligible families.

In recruiting other health care providers, the Department has to consider the quality and cost of the health care. It would not, for example, be appropriate to enroll emergency rooms as PGH providers, even though 9 percent of the families surveyed in the study named emergency rooms as their usual source of medical care. Hospital outpatient departments are also not very likely candidates for PGH, given the current outpatient department rates for well-child visits, the restructuring of the recordkeeping systems that would be required, and the necessary revision of the claims form. At the current rate set for PGH screens, there is no incentive for hospitals to make those changes.

Although hospital clinics are not likely to become PGH providers, they could be encouraged to develop working relationships with PGH to assure the availability of PGH services to their population. In addition, independent physicians who practice in outpatient departments are likely candidates for the PGH program. Recent efforts to recruit these physicians should continue.

Finally, new Federal regulations allow continuing care providers, such as health maintenance organizations, to provide PGH services under a blanket agreement with the Department of Public Welfare. In the past, children enrolled with such providers were not formally enrolled in PGH, even if they were receiving the same type of care PGH provides. The recent change in the regulations will not affect the care they receive, but it will recognize the fact that many children do receive regular preventive health care from their continuing care provider.

CHAPTER IV

EXPANSION OF THE RECRUITMENT AND SERVICE DELIVERY SYSTEM

A substantial proportion of the children eligible for Project Good Health do not receive regular, well-child medical care. Estimates of the size of this proportion range from about 20 percent, based on the self-reports of families in the survey of eligible families, to about 55 percent, based on an analysis of data reported by selected local offices of families newly eligible for PGH. With even the most optimistic estimate showing that one-fifth of all eligible children are not receiving routine medical care, this represents an important group for PGH to serve.

Current PGH outreach efforts already give top priority to children who report they are not receiving regular medical and dental care, as defined by the PGH protocol and periodicity schedule, but PGH outreach has not enrolled most of these children. Even assuming that all children enrolled by PGH field workers are those without regular medical care, the children enrolled by field workers make up about 7 percent of those eligible for the program. This leaves approximately 15 to 50 percent of eligible children not receiving regular medical care and not reached by PGH outreach efforts.

As discussed in Chapter II, adolescents, non-English speaking families, and children in the care and custody of state agencies are particularly at risk of not receiving regular medical care or PGH services.

This chapter discusses a variety of organizations and institutions through which PGH might reach children who do not receive regular medical care. Consideration is given to the possibilities and issues presented by an expanded service delivery and recruitment system that includes family planning clinics, community organizations, hospitals, school health programs, preschool programs, state agencies with children in their care and custody, and public health agencies. Throughout the chapter, references are made to programs in other states. These are summarized in Appendix G.

FINDINGS AND ISSUES

A. Family Planning Clinics

Approximately 60 family planning clinics throughout Massachusetts are certified to provide services to Medicaid-eligible clients. The clinics offer medical and laboratory services, counseling, referral, follow-up, and, in the majority of cases, community education and outreach. Because most clinics offer comprehensive physical examinations, they could serve as PGH providers. Family planning clinics seem especially promising as PGH providers for adolescents, the age group most underenrolled in PGH.

1. Family planning clinics have the potential to provide PGH services to a significant number of adolescents.

   a. Statistics on the utilization of services of family planning clinics indicate that in clinics funded by the Maternal and Child Health Program, approximately 23 percent of the clients served are adolescents. In clinics funded by Federal Title X, 31,218 clients, or about 37 percent of all clients served, were adolescents in 1982, triple the number in 1975. An examination of quarterly reports of family planning clinics revealed that most of them make substantial efforts to reach out to adolescents.

   b. According to the Select Panel for the Promotion of Child Health of the Federal Department of Health and Human Services, convenience is particulary important to adolescents. Also, teenagers often want to obtain health care on their own without parental involvement. Confidentiality is especially important to adolescents in obtaining services such as family planning or treatment for drug abuse.

      Family planning clinics do not share their records with other agencies, and have developed methods of contacting their clients while continuing to ensure confidentiality.

2. PGH regulations have been amended to allow family planning clinics to conduct PGH examinations, but issues between PGH and family planning agencies remain unresolved.

   a. In 1982, the PGH staff met with the family planning agencies to address issues that were preventing the agencies from becoming PGH providers. As a result of these discussions, the PGH regulations were amended to allow family planning clinics to conduct PGH examinations as part of family planning visits.

   b. Additionally, an agreement between PGH and the family planning agencies was drafted to address the concerns of the agencies regarding confidentiality and the required PGH follow-up. Although a significant amount of work went into the negotiations between PGH and family planning agencies, a number of issues remained unresolved. These issues included:

      - Verification of the client's Medicaid eligibility before conducting a PGH screening. According to staff interviewed in several family planning agencies, adolescents often have difficulty obtaining access to a parent's Medicaid card.

      - The conflict between confidentiality regarding family planning services and the Federal requirement that PGH track the services received by participants. According to the family planning staff, their agencies have developed methods of contacting their clients which preserve confidentiality. This is very important to adolescents who may fear that their parents will be notified if they use family planning services. PGH claims, however, generate reports that include the names of clients. This is necessary in order to track the services received and to ensure that necessary follow-up is provided.

In addition, according to PGH staff, many of the previous areas of agreement concerning confidentiality and recordkeeping have to be renegotiated to ensure that the procedures can be adapted to the new Medicaid Management Information System (MMIS).

B. Community Organizations

Community and social service agencies and religious organizations could provide important links to PGH for families and individuals without regular medical care. Although most adolescents are reluctant to use doctors, except in emergency situations, some adolescents are in regular contact with community and social service agencies. Many non-English speaking families, especially recent immigrant groups, rely upon religious and social organizations for assistance in becoming settled and in obtaining access to other services.

1. Other states frequently work with neighborhood organizations and services.

In North Carolina, for example, the EPSDT staff work with a variety of community groups, especially churches. In Michigan, a special recruitment campaign for the Special Supplemental Food Program for Women, Infants and Children (WIC) included local efforts tailored by neighborhood. Michigan WIC agencies contacted neighborhood organizations, block clubs, recreation centers, churches, community organizations, union halls, laundramats, post offices, food distribution sites, grocery stores, pharmacies, and other appropriate groups. In combination with a mass media campaign, this effort resulted in 40,000 new WIC participants in five months.

2. Small grants awarded by the Department of Public Welfare to community organizations can provide an effective means of outreach.

In the spring and summer of 1984, the Department conducted an intensive campaign of food stamp outreach to targeted communities across the state. A number of community agencies received grants of $3000 to $7000 to take part in this campaign. Their efforts proved to be the most effective component of the campaign.

These agencies undertook a variety of activities to inform families about food stamps and to work with interested families to obtain food stamps. During the two months that the community agencies were active in this campaign, food stamp applications in the targeted areas increased by a significantly higher amount than applications in other areas.

3. Community organizations are in contact with recent immigrant populations, such as Southeast Asians.

According to Welfare Department staff who work with Southeast Asian refugees, the Southeast Asian community contains a number of well-organized community groups. Called mutual assistance associations, many are organized specifically for the purpose of helping recent Southeast Asian immigrants become settled in their new communities. Some of these organizations already provide personal assistance to refugees in obtaining benefits or other services such as medical care, according to the WIC staff member responsible for services to Southeast Asian refugees.

4. The PGH training specialists work with community and social service agencies which serve adolescents.

PGH training specialists have met with representatives of approximately 30 agencies with special programs for adolescents across the Commonwealth. The purpose of the meetings is to explain the PGH program and the ways in which adolescents might benefit from participation. This training is an ongoing PGH function.

C. Hospitals

Infants are a particularly important target group for preventive care. Outreach through the hospitals would probably result in the registration of more newborns in PGH. Mothers are likely to be concerned about regular health care for their infants and may not as yet have made arrangements with non-PGH providers.

1. In some states, representatives of the EPSDT program regularly go to hospitals to register infants in the program.

One county in New York maintains an infant registry. Public health nurses under contract with EPSDT visit the mothers of newborn babies in local hospitals to inform them of the benefits of the program and to register them. They also try to enroll other children in the family. While 90 percent of the mothers enroll their infants, there is no information about how long people stay in the program.

California's EPSDT program has a similar arrangement with maternity and pediatric units in local hospitals.

2. In Massachusetts, the Department of Public Health has set up a registry of high risk infants in hospitals but it is not tied to PGH.

DPH recently set up a program to identify and track infants at risk of developing serious health problems. The program began without involvement of PGH. Consequently, information, such as the mother's social security number, which would enable a PGH worker to identify infants eligible for PGH is not included in the hospital reporting forms.

D. School Health Programs

Children already spend a large portion of their time in school. Through developing links with schools, PGH could go to the children rather than waiting for the children to come to a PGH medical care provider. School collaboration with PGH could take the form of school health programs which screen children or referral systems to PGH through the health care facilities within the school.

In Massachusetts and in other states, school systems have established such linkages with EPSDT. Some school systems actually provide EPSDT screenings. An examination of these systems offers useful information as to how such links might be created. Most schools, however, would have to make substantial changes in their health programs in order to provide EPDST services. Thus, it is also important to examine school health programs that successfully make referrals to other health care providers who participate in EPSDT.

1. The most comprehensive model for school-PGH collaboration is for schools to provide PGH screenings and limited treatment services, and refer students needing further diagnosis and treatment to other medical care providers.

   a. Lawrence Children's Health Project

      In 1979, only about six percent of the eligible PGH population in Lawrence, Massachusetts were receiving PGH screens. In an effort to increase the availability and utilization of preventive health care for school-aged children, the Merrimack Education Center, the Lawrence Public Schools, and the Department of Public Welfare applied jointly to the Federal Health Care Financing Administration for funding of the Lawrence Children's Health Project, a demonstration program to provide PGH services in the Lawrence public schools.

      Six of the 13 elementary schools in Lawrence became participants in the project. By the end of the school year 1981-1982, 72 percent of the school children in the six schools had joined the project and had been screened. A screening included a health history, a physical examination by a nurse practitioner, certain laboratory tests, and a neurological and motor development assessment. The project maintained an effective system for referrals and follow-up treatment.

      When the Federal demonstration funds ran out, the Lawrence schools discontinued PGH screenings and the Greater Lawrence Family Health Center became a PGH provider.

b. Hartford, Connecticut Public Schools

The Hartford Public Schools have a large health care staff consisting of part-time physicians and dentists, nurse practitioners, nurses' aides, and dental hygienists. The health program provides physical examinations, including vision and hearing tests, scoliosis screenings, immunizations, and dental screenings and cleanings.

Through an agreement between the Department of Education and the Department of Income Maintenance, physical examinations provided to Medicaid eligible children may be billed as EPSDT examinations. The parents are asked, at the time they register their children for school, to notify the school if their children are eligible for Medicaid or have health insurance. The schools are responsible for ensuring the provision of any necessary health care referrals for students who receive EPSDT service.

c. St. Paul, Minnesota High School

The St. Paul school health clinics, located in four of the St. Paul high schools, provide routine health assessments and physicals, laboratory screenings, treatment for infections of the ear, upper respiratory system and urinary tract, and counseling services in the areas of nutrition, personal hygiene, sexuality, and substance abuse.

The staff at each clinic consists of a family planning nurse practitioner, clinic attendant, social worker, obstetrician/gynecologist, pediatrician, pediatric nurse associate, nutritionist, health educator, and a dental hygienist.

The clinics are certified as EPSDT providers; whenever applicable, well-child visits are billed as EPSDT examinations. The clinics have effective tracking systems which enable them to contact students who are in need of follow-up services or who are due for check-ups.

2. Some schools provide more limited health services, but refer students to other medical care providers.

In Cambridge, Massachusetts, the high school clinic is located in Cambridge Rindge and Latin School and makes health services available to all high school students attending Cambridge Public Schools. According to clinic staff members, the clinic provides physical examinations to all ninth graders and new entry students and provides for administering immunizations. The clinic staff makes any necessary referrals for services and attempts to follow up to ensure that the students actually keep the referral appointments.

The clinic staff consists of one nurse practitioner, two health aides, and one family planning counselor who works one morning a week. According to the staff member interviewed, limitations of the clinic's physical plant make it ineligible for state licensure, and therefore the clinic cannot charge for its services. This limits the health services that the clinic can provide in the school. However, the referral network is extensive. The high school clinic is linked with an adolescent health care clinic at Cambridge City Hospital, an arrangement that is particularly beneficial since the hospital is located only a few blocks from the school.

The clinics in the elementary schools provide health care to students in the schools and to the Cambridge community. The school health services for students consist of vision and hearing tests and physical examinations. Other sick visits and preventive care are provided on a fee-for-service basis.

3. Establishing greater collaboration between school health programs and PGH will require the resolution of outstanding administrative and confidentiality issues.

In order for the medical examination received by a Medicaid-eligible child to count as an EPSDT examination, the provider (the school or the school-based hospital clinic) must be able to identify that the child is, in fact, eligible for Medicaid at the time the services are provided. The provider must also conform with the protocol and record-keeping mandated by PGH.

According to staff members at the St. Paul school health clinic, the identification of Medicaid eligibility is difficult. First, the child's eligibility can change during the school year. Second, there is a problem in labeling a child in a school as a Medicaid recipient. In order to ensure that these children are not treated differently from non-Medicaid recipients by teachers and administrators, confidentiality of school health records is important.

In order to implement a referral system between the school health services and the PGH program, additional responsibilities would have to be undertaken by the schools, such as recordkeeping and assistance in the implementation of the system. Possible additional funding and community and school administrative support would have to be obtained.

E. Preschool Programs

Preschool and day care programs provide an opportunity to reach the families of young children who are eligible for PGH. Although Massachusetts does not have a comprehensive system of preschools comparable to its elementary and secondary systems, more formal collaboration with day care centers and preschool programs could enable PGH to reach many families who might not have regular medical care.

1. EPSDT programs in other states have extensive agreements with preschool programs.

In New York, the Chemung County EPSDT program has agreements with all preschool programs in the county to refer children to EPSDT. Participating institutions include private nursery schools, the Head Start Program, and Elmira City School District's pre-kindergarten program. In some counties in California, Head Start is an EPSDT provider.

2. In Massachusetts, PGH staff have some contact with Head Start and day care programs to inform them about PGH but no formal referral process has been established.

a. The PGH program and the New England Regional Office of the Administration for Children and Youth, the Federal agency which administers Head Start programs in Massachusetts, have signed an interagency agreement to maximize cooperation between the programs.

PGH staff have met with the coordinators of individual Head Start programs on a regional basis to make them aware of the program. PGH staff also participate in Head Start enrollment weeks and have spoken at the statewide meeting of the Head Start health coordinators.

b. PGH staff are working with the DPH preschool health initiative in developing a health manual for day care providers. The PGH staff are writing a section of the manual which will make the providers aware of PGH.

Recently, PGH staff have spoken at two statewide conferences for day care providers and conducted a workshop at one to provide more detailed information about PGH.

F. State Agencies with Children in Their Care and Custody

As reported in Chapter II, the Department of Social Services (DSS), the Department of Youth Services (DYS), and the Department of Mental Health (DMH) have custody of over 13,000 children under age 21 who are eligible for PGH services. Very few of these children are enrolled in PGH. Within the last year, the problem of providing regular and preventive health care for these children has become a priority.

1. The Executive Office of Human Services Child Health Task Force reached an agreement on actions to be taken by DSS to strengthen the health care provided to children in its custody.

Since the largest number of affected children are in the custody of DSS, the Task Force's first efforts have focused on DSS. The agreement reached in the fall of 1984 states that:

a. DSS will establish a "Medical Passport" for all children in the agency's care.

According to the Health Services Specialist with DSS, the agency has field tested and is preparing to implement a "Medical Passport" for all children in substitute care. The passport is an abbreviated health record contained in a small folder much like a passport which will be carried by the child to each health care provider the child uses. This health record is designed to give each new provider some basic information about the child and to provide some continuity in the care of children who are often transferred from one care setting to another. The PGH protocol and periodicity schedule are contained within the passport.

b. Children in the care of DSS will be tracked through a system similar to PGH.

Under the terms of the Vega stipulation, DSS has responsibility for all PGH tracking requirements for children in DSS custody. DSS does not plan to enroll the children in their care and custody in PGH. This decision was made because DSS felt that the PGH tracking system did not meet the needs of children in substitute care, and because of the potential difficulties in coordinating the health care of children when personnel from different agencies are responsible for different aspects of that care.

Instead, the agency intends to set up a parallel system designed just for DSS children. This system will use the same medical protocol and periodicity schedule as PGH, and, like PGH, the children will be tracked through a computerized system to be sure they receive the screenings and treatment required.

DSS staff expect that children taken into the care of DSS after January 15, 1985 will become part of this system immediately. Children in the agency's care before January 15 will be transferred to the system on April 1, 1985.

c. DSS will refer the names of the providers used by the children in its care to PGH.

In addition, DSS agreed to refer to PGH the names of health care providers who regularly see children in substitute care for possible recruitment as PGH providers.

2. DYS and DMH also agreed to take actions to improve the health care of children in their custody.

The agencies involved have agreed to:

- Adopt the PGH protocol and periodicity schedule as the standard for routine preventive health care;

- Use the "Medical Passport" for the initial screening and subsequent medical care of all children in substitute care; and

- Develop a system for tracking the health care of the children in their care and custody, or enroll these children in PGH.

G. Public Health Agencies

The Department of Public Health (DPH) is the primary state agency involved in the direct provision of health services. Clients of the programs administered by DPH may also be eligible for PGH. Close coordination between PGH and public health programs administered by DPH could be an essential component of an enrollment strategy for PGH. As with school health programs and their relationship to PGH, it is important to examine the range of alternatives for PGH collaboration with public health programs.

1. PGH has working relationships with some public health programs, but the degree of coordination varies from program to program.

   a. As required by Federal regulation, PGH has signed an interagency agreement with the Maternal and Child Health Programs of the Department of Public Health. The agreement states that the two programs will cooperate in promoting PGH among the eligible population, but contains few specifics as to how this will be accomplished.

   b. According to PGH staff, they have informal working relationships with the staff of individual programs administered by Maternal and Child Health Programs, such as the Special Supplemental Food Program for Women, Infants, and Children (WIC).

      However, these ties do not cover all the programs that reach PGH-eligible children. As described earlier, DPH recently set up a program to identify infants at risk of developing serious health problems. Because this program was established without any contact with PGH, information which would have enabled a PGH worker to tell which high risk infants are eligible for PGH was not included on the hospital reporting form.

   c. At present, no formal structure exists for ensuring that eligible children who are in DPH programs receive PGH services. However, PGH staff report that they are negotiating with DPH to have all Maternal and Child, Infant and Youth program contracts with private providers include the PGH protocol and periodicity schedule. According to PGH staff, with this provision, all children served under those contracts would receive PGH services and be counted in PGH enrollment.

2. DPH programs present opportunities to bring non-English speaking families and adolescents into PGH.

   a. The WIC program has recently begun a special effort to reach Southeast Asian refugees. This outreach effort provides both bilingual staff and culturally appropriate services, such as foods that are traditionally found in the refugees' diets.

      Most important, in the view of the WIC staff member responsible for services to Southeast Asian refugees, is the training of individuals from the Southeast Asian community in nutrition and the services available through WIC. These individuals will function in a paraprofessional capacity, paid by the WIC program, to find eligible individuals and to actually take them to clinics and physicians who provide WIC benefits. These special Southeast Asian outreach workers will also be informed about the benefits available under other health programs.

      WIC staff have expressed their willingness to have these workers refer clients to PGH if PGH information and materials were provided to them.

   b. PGH staff are working with the Director of DPH's Adolescent and Teen Parenting programs to develop ways to include PGH in DPH adolescent programs. One possibility is the incorporation of the PGH protocol and periodicity schedule in all future DPH adolescent program contracts.

3. In some states, the public health agency is involved in the administration of the EPSDT program.

   a. According to the state profile directory compiled by the Health Care Financing Administration (HCFA), in 12 states the state public health or combined health and social services departments administer the EPSDT program. Federal regulations specify that the EPSDT program must be administered by the state Medicaid agency. Medicaid can, however, contract with another agency for the actual operation of the program.

   b. In a few states, public health staff actually conduct the EPSDT screenings. In Michigan, for example, the state Medicaid agency contracts with the state public health agency, which in turn subcontracts with the local health departments. The local health departments do outreach as well as administer screens. Children needing treatment are referred to a private Medicaid provider. Michigan recently decided to allow some private providers also to do outreach and administer screenings. According to one state official, this change was motivated by concerns about continuity of care and the high costs of local health department screenings.

The state of Maryland is also planning to contract with city and county health departments to do all phases of EPSDT. According to an analysis by the Children's Defense Fund, public health staff will take care of outreach, tracking, provider recruitment, assistance in scheduling appointments and transportation, and coordination with other programs.

IMPLICATIONS

For poor families without regular medical care, preventive health care may not be a high priority. To increase the effectiveness of its outreach to these families, PGH needs to make preventive health care easier to obtain and to strengthen the persuasiveness of the outreach message. PGH is a voluntary program. The Department of Public Welfare does not require an eligible child to participate in PGH, nor does it restrict an eligible family's choice of medical care provider within the Medicaid system. PGH enrollment is dependent upon an outreach system that includes information, persuasion and client education, and a delivery system that includes an adequate, accessible pool of providers.

This chapter presented an assessment of the strategy of creating an expanded recruitment and delivery system that includes organizations and agencies which are already in contact with PGH-eligible families. The findings suggest that such a system would be helpful, both in outreach to clients and in increasing the accessibility of PGH services. Some of the organizations and agencies reviewed could provide PGH screenings directly; in other cases, they could serve as sources of referrals.

The strategy of coordinating with organizations which already serve PGH-eligible families and individuals seems particularly promising as a way to reach the groups, discussed in Chapter II, that are most underrepresented in PGH. Family planning clinics, DPH adolescent programs and school health programs could all play important roles in making PGH services accessible to adolescents. By linking up with the special WIC outreach effort to Southeast Asian immigrants, and contracting with selected community organizations to inform people about Project Good Health, PGH could greatly expand its recruitment of non-English speaking families. Children in the care and custody of DSS, DYS and DMH will all benefit from the full implementation of agreements recently reached between each of these state agencies and PGH.

Most of the organizations and agencies reviewed in this chapter, however, present issues that must be resolved if they are to become part of an expanded PGH recruitment and delivery system. The steps PGH should take to create this new system derive from an analysis of both the potential of the organizations and agencies in relation to PGH and the problems they present.

Hospitals provide a means of reaching virtually all newborns who are eligible for PGH. PGH staff should explore the possibility of regularly visiting hospitals to recruit families. In setting up an infant registry comparable to those used in other states, PGH staff would need to work with hospital staff to develop a system for identifying Medicaid-eligible families without violating the clients' confidentiality. PGH staff should also work with the staff in the DPH high risk infant identification program to develop procedures for identifying and contacting the PGH-eligible children in that group.

Elementary and high school health programs offer the potential for reaching large numbers of children and youth eligible for PGH. Most school systems in the state, however, do not currently have comprehensive health programs and thus cannot actually conduct PGH screenings. It would be a major effort to restructure these programs to enable them to become PGH providers. Such an effort does not seem advisable now, especially when there are other viable strategies for bringing children into PGH.

In the short run, PGH staff should identify and recruit as providers school systems which already have comprehensive health programs. In the special case of Lawrence, staff should work with the Greater Lawrence Family Health Center to ensure that participants in PGH were all transferred to the Health Center when the Children's Health Project in the schools was dismantled. As a longer range strategy, PGH should work with other state agencies to develop a comprehensive plan for school-PGH collaboration. The goal should be to establish a clear role for elementary and secondary schools in identifying and referring children without regular medical care to PGH.

Like public schools, preschools have regular contact with a wide range of families, including many without regular medical care. The state, however, does not have a universal or comprehensive system of early childhood education. Not all children attend day care centers or preschools, and the system is decentralized. PGH would have to negotiate with hundreds of individual providers to make them formally part of the PGH referral system. While this effort does not seem advisable in the short run for all preschool programs, PGH should consider contracting with all Head Start programs in the state to refer all eligible children to PGH.

In addition, PGH should continue its current efforts to inform preschool and daycare programs about PGH, for example, through meetings with Head Start health coordinators and parents, participation in day care conferences and collaboration with Public Health staff to produce a health manual for day care providers.

The Department of Public Health also presents important opportunities for recruiting families without regular medical care into PGH. Through a wide array of programs, such as WIC, the Adolescent and Teen Parenting Program, and the High Risk Infant Identification Program, DPH works with families that PGH may not reach. The informal relationships PGH staff have with staff in some DPH programs do not provide enough coordination. The links between PGH and the Department of Public Health programs that work with families eligible for PGH should be strengthened.

One means of strengthening coordination would be to involve DPH directly in the administration of PGH, as is done in a number of other states. Such a change, however, does not seem advisable. While it might bring PGH closer to other health programs working with the same clients and thus increase the coordination of client identification, it would also remove the program from the access to current and potential PGH providers it now has as part of the state Medicaid agency. Given the high proportion of families who enter PGH through their health providers and the importance of recruiting and retaining providers in PGH, as described in Chapter III, separating PGH from health care providers seems unwise.

A preferable strategy for strengthening the links is to make more formal the role of DPH program staff in the recruitment and referral of families and individuals to PGH. The inclusion of the PGH protocol and periodicity schedule in all DPH Maternal and Child, Infant and Youth contracts is an important first step. PGH staff should pursue similar negotiations with other public health programs. In addition, PGH administrators should consider writing performance-based contracts with DPH to recruit children to PGH. The model has been used successfully by the Welfare Department in its Employment and Training program, ET Choices. The Department contracted with the Division of Employment Security and Job Training Partnership Act (JTPA) agencies for assistance in placing Welfare Department clients in jobs and training programs.

CHAPTER V

RESTRUCTURING OF STAFF ROLES AND RESPONSIBILITIES

Four-fifths of all PGH staff work in local welfare offices. They are deployed roughly on the basis of the number of PGH-eligible children in an office. The large offices each have a PGH specialist assigned to them; the largest office, in Springfield, has two. Only 14 offices have a full-time specialist. Smaller local offices are covered on a part-time basis by a specialist from the nearest area office. The 19 largest offices also have a PGH technician who handles administrative duties for the program. Table V-1 shows the assignment of specialists and technicians to local offices.

Although PGH field staff work in local welfare offices, they do not report to the local office directors. The directors and the local office staff under their supervision are part of the Division of Eligibility Operations (DEO), the unit in the Welfare Department responsible for the day-to-day operations of the local offices. In contrast, all PGH specialists and technicians are supervised by one of six regional PGH supervisors who report to the field coordinator in the Central Office's Medicaid Division. The purpose of the PGH supervisory structure is to create a group of field workers whose sole responsibility is to enroll eligible children and to track participants in PGH.

The PGH workers are responsible for contacting new client families through outreach methods such as letters, telephone calls, welfare office interviews or home visits. The workers also provide certain types of assistance to eligible families, including referrals to medical and dental providers, or help with transportation or child care. In addition, the workers are responsible for tracking children enrolled in PGH and monitoring whether they receive the right number of screenings at the designated times and any necessary follow-up treatment.

In order to make their first contact with families eligible for PGH, the workers rely on information obtained by the AFDC and Medicaid eligibility workers during the application interview. To track assistance, screenings and treatment provided to eligible children, the workers use a computerized subsystem of the Medicaid Management Information System (MMIS).

As reported in Chapter II, the worker's current outreach efforts account for a quarter of the total PGH enrollment. Thus their activities have resulted in the enrollment of 7 percent of the children eligible for PGH services. This chapter examines the role of PGH field staff in order to understand the constraints which limit their effectiveness. The chapter is divided into two sections: the first analyzes the workers' duties and effectiveness, and the second examines the limitations of the supports and resources currently available to workers in carrying out their responsibilities.

FINDINGS AND ISSUES

A. Worker Duties

PGH program requirements specify who is to be contacted, and the form, frequency, and content of the contacts; workers are not held accountable for numbers of enrollments. The emphasis on contacts is a result of the detailed nature of the Federal regulations and of the specific conditions in the stipulation signed by the Department in the Vega case.

The Federal regulations in effect when the PGH program began specified that families be notified no later than 60 days following the determination of their eligibility for AFDC or Medicaid. The regulations also required that the contact be both in writing and face-to-face, and that the materials used to inform families about the program contain information about thirteen specified items, including the benefits of preventive health services.

The stipulation in the Vega case is even more detailed. For example, the outreach section of the stipulation includes the instructions:

> The Department will explain the program and its advantages to each AFDC household containing persons eligible for the program and will inquire whether the household is interested in participating in the program. The communication described in the preceding sentence shall be face-to-face on an individual basis. If the household is interested and committed to participate, the Department will follow the relevant requirements of paragraph 17 and no further outreach is required as long as participation continues. If the household is interested but not yet committed to participate, the Department will arrange for an additional, detailed communication about the program consistent with this paragraph 2 and paragraph 17 and will offer face-to-face, an opportunity for a face-to-face communication on an individual basis. The additional, detailed communication may be in writing.

In the summer of 1984, the evaluation staff sent a written questionnaire to all PGH specialists and technicians and a separate questionnaire to supervisors. The specialist/technician questionnaire asked detailed questions about how these workers spend their time. Both questionnaires asked for opinions about problems with the program and suggestions for improving it. With the exceptions of findings 1 and 5, the data for this section come primarily from this survey of field workers.

1. Local offices vary widely in the number of families enrolled in PGH per PGH worker.

   As Table V-1 shows, the number of families enrolled in PGH per worker ranges from a low of 116 to a high of 2750, with a statewide average of 997 per worker. These figures suggest that staff in some offices are more effective in recruiting families to PGH than others.

   No firm conclusions can be drawn, however, since these data include all children enrolled in the program. At the present time, the PGH

TABLE V - 1

PGH ENROLLMENT AND WORKER DISTRIBUTION

rea Office	Total PGH Enrollees	Total PGH Eligibles	Total Percent Enrolled	Number of PGH Workers: Specialists/ Technicians	Enrollees Per Worker	Eligibles Per Worker
hurch ST.	511	6633	8	1 / 1	256	3317
oxbury CR.	296	7242	4	1 / 1	148	3621
ancock ST.	317	9397	3	1 / 1	159	4699
awkins ST.	309	5294	6	.5 / 0	618	10558
oslindale	654	8316	8	1 / 1	327	4158
rove Hall	174	7207	2	.5 / 1	116	4805
OSTON	2261	44089	5	5 / 5	226	4409
reenfield	903	3463	26	1 / 0	903	3463
olyoke	3812	9176	42	1 / 1	1906	4588
orthampton	767	1680	46	.5 / 0	1534	3360
ittsfield	1768	5321	33	1 / 1	884	2661
oringfield	5629	17330	32	2 / 1	1876	5777
estfield	934	2769	34	.5 / 0	1868	5538
PRINGFIELD	13813	39739	35	6 / 3	1535	4415
tchburg	1774	4325	41	.8 / 1	986	2403
lford	1033	2346	44	1 / 0	1033	2346
outhbridge	1202	3962	30	1 / 1	668	2201
emp/Gardner	445	1993	22	.2 / 0	2225	9965
orcester	2123	11152	19	1 / 1	1062	5576
ORCESTER	6577	23778	28	4 / 3	940	3397
everly	1066	1957	54	.5 / 0	2132	3914
helsea	775	5024	15	1 / 1	388	2512
averhill	1759	3370	52	1 /.5	1173	2247
awrence	2596	8217	32	1 /.5	1731	5478
owell	1070	6936	15	1 / 1	535	3468
ynn	2313	6071	38	1 / 1	1157	3036
alden	1052	4015	26	1 / 0	1052	4015
alem	930	2359	39	.5 / 0	1860	4718
akefield	190	809	23	.4 / 0	475	2023
AWRENCE	11751	38758	30	7.4 / 3	1031	3400
rookline	351	2771	13	.5 / 0	702	5542
ambridge	505	3036	17	.5 / 0	1010	6072
ramingham	714	2529	28	.5 / 0	1428	5058
orwood	382	1205	32	.5 / 0	764	2410
unicy	1904	4797	40	1 / 1	1058	2665
omerville	428	2983	14	.5 / 0	856	5966

(TABLE V - 1 continued)

Waltham	297	1507	20	.5 / 0	594	3014
Woburn	445	1598	28	.6 / 0	742	2663
GREATER BOSTON	5026	20426	25	4.6 / 1	898	3648
Attleboro	287	2145	13	.5 / 1	191	1430
Brockton	3259	8392	39	1 / 1	1630	4196
Fall River	2984	5973	50	1 / 1	1492	2987
Falmouth	1215	3696	33	1 / 0	1215	3696
New Bedford	4675	9071	52	.7 / 1	2750	5336
Plymouth	981	2586	38	1 / 1	981	2586
Taunton	735	3251	23	.5 / 0	1470	6502
NEW BEDFORD	14136	35114	40	5.7 / 5	1321	3282

data system does not provide an office by office breakdown of which children are enrolled through their medical care providers and which are enrolled through the PGH workers' assistance. As stated earlier, only a quarter of the total PGH enrollment is attributable to worker assistance. Also as stated earlier, total enrollment is significantly correlated to the number of PGH providers in an area but not to the number of PGH staff. These findings indicate that worker effectiveness should be assessed on the basis of only the children they enroll.

2. PGH workers report that they spend the majority of their time providing outreach and assistance to PGH-eligible families.

Table V-2 shows that the field workers have a variety of responsibilities. As would be expected, however, they report that the largest portion of their time -- 40 percent for specialists and 45 percent for technicians -- is spent doing outreach and assisting families eligible for PGH. The remainder of their time is spent following up and tracking PGH recipients; documenting case records and the computer tracking system; contacting health providers; and helping clients not eligible for PGH.

3. The primary means of outreach have a low payoff in terms of enrollment.

a. The specialists spend an average of 9 hours a week and the technicians an average of 16.5 hours per week sending letters to PGH-eligible families (See Table V-3). This means that, on average, 36 percent of the time the PGH specialist spends on outreach and 76 percent of the outreach time of the PGH technician is taken up with sending out letters. Yet by the workers reports, letters produce the fewest contacts for the time spent (See Table V-3).

Also, while letters may be effective in informing eligible families about PGH, that knowledge does not necessarily result in enrollment. In a telephone survey of PGH eligible families, 52 percent of the families whose children were not enrolled in PGH had heard about the program through a letter. By contrast, only 32 percent of the families whose children were enrolled had heard about it through a letter.

b. The specialists spend 15 hours a week and technicians spend an average of 5 hours a week making telephone calls to eligible families. By their estimates, specialists assist 0.7 families per hour of phone calling and technicians assist 1.4 families per hour spent.

The difficulties involved in reaching people by phone were corroborated by the intensive outreach project conducted in four geographic communities in the summer of 1984. Despite concerted attempts to reach all PGH-eligible families, project staff succeeded in enrolling roughly the same percentage (4-6 percent) of families in PGH.

TABLE V - 2

ALLOCATION OF PGH WORKER TIME

Worker activity	Percent of specialist time	Percent of technician ti
Doing outreach & assisting PGH eligibles	40	45
Following up and tracking PGH participants	20	20
Providing information and help to clients not eligible for PGH	10	10
Contacting PGH/Medicaid providers, other than for client	2	0
Documenting field work in case records	15	10
Entering and updating information on computer tracking system	10	5
Other*	4	8

*Includes:

Attending meetings (9 responses)
Performing clerical duties (8 responses)
Consulting with supervisor (3 responses)
Contacting persons in other agencies (2 responses)
Travel (2 responses)

TABLE V - 3

OUTREACH ACTIVITIES

TIME SPENT PER WEEK ON OUTREACH ACTIVITIES

Type of outreach	Median hours spent by specialists	Median hours spent by technicians
Letters	9.0	16.5
Phone calls	15.0	5.0
Office visits	.5	.25
Home visits	.5	.0
Total	25.0	21.75

PARTICIPANTS ASSISTED PER HOUR SPENT ON EACH TYPE OF OUTREACH

Type of outreach	Specialist assists per hour of outreach	Technician assists per hour of outreach
Letters	.4	.4
Phone calls	.7	1.4
Office visits	2.0	4.0
Home visits	8.0	-

c. Workers report that face-to-face visits with clients in the local welfare office or in the clients' homes occur infrequently. However, these contacts are several times more effective in enrolling eligible children than telephone calls. The effectiveness of face-to-face visits compared to letters is even greater (See Table V-3).

d. Suggestions from PGH field workers for ways to increase the effectiveness of outreach included:

- Face-to-face meetings with eligible families;
- Regular visits to other health-related agencies to generate PGH referrals;
- Special training in sales techniques to enable workers to "sell" PGH to clients more effectively;
- Promotional activities such as booths at shopping centers, balloons for children, and PGH workers stationed at community agencies.

4. PGH workers report that a high proportion of their time is spent on paperwork.

a. One-fourth of the specialists' time is reportedly spent on paperwork: 15 percent documenting field work in case records and 10 percent entering and updating information on the computer tracking system. The technicians report that they spend 15 percent of their time on these activities. (See Table V-2.)

b. In responding to the survey, one PGH technician listed her duties as follows:

> I do all the follow-up calls, this includes about 8-10 calls for every outreach call...Do all the filing, gather the Medicaid and AFDC logs of all the newly opened cases of people under 21, then check that I have received all these referrals...type up the statistics form...Send out all the initial letters...to every client that has been approved that is under 21. (according to their health status). Send office visit letters... when I cannot get in contact with a client the last resort is to send them this letter...
>
> When the printouts come in send letters...to all the newly transferred in clients. Also from the printout send... letters to those people who need to get to the dentists that have not been within a certain length of time.
>
> When new lists are made up of the providers send them all letters to check they are still on Medicaid, then after all the information is in type new lists, this keeps the provider lists up to date on all medical and dental providers.

..Fill out a...computer input document on every client I have been able to assist either when they make their appointment or when the appointment has been confirmed. Fill out contact sheets on each client I make a phone call to...

c. Many of the workers surveyed feel that their jobs consist of too much paperwork and not enough face-to-face client contact. As one worker noted:

> If we have a bit less paperwork it might enable the Specialists to get out in the field and visit not only other agencies but more home visits where the face-to-face interviews I have made are much more satisfying to client and worker...I realize a smaller office is able to do things in a more in depth way but where we have such a large number of recipients to work for, we are not able to do all the things required such as making appointments for clients.

5. New Federal regulations provide EPSDT programs with more flexibility in the means used to contact eligible families.

New regulations governing the operations of EPSDT take effect on January 29, 1985. These regulations allow states more flexibility in informing eligible families about the program. Rather than stating how the initial contacts must take place, the new regulations require that families be "effectively" notified about the program, using some combination of written and oral methods. These regulations also state that information must be provided about four items, including the benefits of preventive health care, and that processes must be in place to inform all families, generally within 60 days of the date the families are determined to be eligible.

While these new regulations potentially provide PGH with more discretion in choosing the methods that appear to be most effective in informing eligible families about the program, the program remains bound by the court stipulation in the Vega case.

6. PGH workers spend a substantial amount of their time helping adults not eligible for PGH.

a. In response to a question on the survey, PGH specialists and technicians estimated that they spend 10 percent of their time providing information and help to clients not eligible for PGH (Table V-2.)

> All workers reported that they had helped the parents of PGH children; three-quarters (76 percent) reported providing help to non-PGH Medicaid clients who were disabled; two-thirds (68 percent) reported giving help to Medicaid clients aged 65 or over; and nearly two-thirds (63 percent) gave help to relatives of PGH children other than parents (Table V-4).

TABLE V - 4

HELP FOR MEDICAID CLIENTS NOT ELIGIBLE FOR PGH

Type of clients	Percent of workers helping each type
Parents of PGH children	100
Other relatives of PGH children	63
Medicaid clients who are disabled	76
Medicaid clients who are 65 or over	68
Other *	26

*SSI Recipients (1)

WIC Recipients (1)

GR Recipients (5)

Pregnant Women (1)

Medicaid Workers (1)

Those Not Yet Eligible for PA (1)

The type of help given consisted most often of referring clients to Medicaid providers, referring clients to other services, and explaining how to use the Medicaid card. (See Table V-5.)

b. Direct observation of one PGH specialist in December 1983 showed a higher proportion of time spent helping clients not eligible for PGH than the field worker survey indicated. The PGH specialist was observed for about an hour while making calls to recruit eligible children into PGH. More than half of the calls ended with no PGH contact (the parent or child was not home, did not need assistance, etc.), but several of these calls resulted in the specialist's helping someone else in the household. For example:

   - A teenage girl reported that she already had a doctor for herself but that her mother, who was also receiving Medicaid, could not find a physician who spoke Portuguese. The PGH worker was able to supply the name of a Portuguese-speaking physician who accepted Medicaid. The call would not be considered a PGH contact, since the mother was not in the PGH-eligible population.

   - The children in the family had already been to the dentist, but the mother was unable to find a dentist for her husband. Again, the PGH worker was able to supply the information.

   - A mother requested advice as to whether she should seek a second opinion for a treatment that did not seem to be working.

   - Another mother had a complaint about the pediatrician her child had seen.

7. <u>In many local offices, the PGH worker is the person who regularly provides information and help with the Medicaid program</u>.

   a. Medicaid eligibility workers are responsible for determining the eligibility of applicants for the program and may not have the time or the knowledge to help clients with problems. As a result, PGH workers tend to spend a certain amount of their time telling non-PGH clients how to use their Medicaid cards, referring them to medical care providers, and solving problems that do not directly concern PGH.

      As one worker described the situation in response to a question on the worker survey:

      > In this office the PGH specialist is the person having knowledge of the Medicaid program and health care information. Medicaid workers get little or no training on Medicaid programs since their function is to determine eligibility only. The unit does not have provider manuals. The Medicaid workers do not have the time, given they had resources available, to be bothered answering questions presented by clients, so the clients are directed to call Central Office or the PGH Specialist.

TABLE V - 5

HELP FOR MEDICAID CLIENTS

(Including PGH-Eligible Client)

A. SPECIALISTS

Type of help	Frequency of help: Often	Sometimes	Rarely	No Answ
Explaining how to use the Medicaid card	44%	40%	16%	0%
Referring clients to Medicaid providers	96	4	0	0
Giving advice to clients about seeking medical treatment	36	40	24	0
Explaining the Health Connection	24	32	40	4
Referring clients to other services	60	32	8	0
Straightening out problems with Medicaid cards, services, and eligibility	36	32	32	0
Other	20	8	0	72

B. TECHNICIANS

Type of help				
Explaining how to use the Medicaid card	17%	67%	17%	0%
Referring clients to Medicaid providers	92	8	0	0
Giving advice to clients about seeking medical treatment	36	40	24	0
Explaining the Health Connection	24	32	40	4
Referring clients to other services	60	32	8	0
Straightening out problems with Medicaid cards, services, and eligibility	36	32	32	0
Other	20	8	0	72

b. PGH workers are also very often the only staff in a local office who have up-to-date information on Medicaid providers in the area. In many offices, Medicaid staff rely on the PGH worker's Medicaid provider list for information on which medical care providers are currently accepting Medicaid payments.

The survey contained questions on the kinds of providers included on the workers' list. All PGH workers reported that they kept lists of pediatricians and general family practicioners in their area who accept Medicaid recipients. Nearly all (92 percent) kept lists of physicians in other specialities and of community health centers accepting Medicaid. In response to a separate question, many workers (59 percent) reported that their lists included all Medicaid providers in these categories in their areas, not just Medicaid providers participating in PGH. (See Table V-6.)

B. Resources and Supports for Workers

In carrying out their responsibilities, PGH workers rely on support and resources from local welfare offices as well as from the Central Office. Yet most PGH workers reported serious constraints in the support system and resources available to them which limit their effectiveness. This section describes the problems experienced by PGH staff and, in some cases, presents their ideas for improving the situation.

1. Many PGH workers report that they do not get enough information from AFDC and Medicaid eligibility workers.

a. The basic means of transferring information to PGH workers is a referral form filled out by the AFDC and Medicaid eligibility workers as part of a client's application for assistance. (See Appendices H, I, and J.) In their responses to the worker survey, PGH workers reported that these forms were not always filled out completely and accurately. Fewer than half (46 percent) felt the forms were complete and accurate, while 31 percent felt that they were not usually complete and accurate and 15 percent gave mixed responses. Eight percent did not respond to the question (See Table V-7).

On average, respondents to the survey reported that it took five days for the referral forms to reach them. A few workers, however, reported delays of up to 30 days (See Table V-7).

b. Eligibility workers are required to send referral forms to the PGH workers only for newly eligible children. When the eligibility of a family is periodically redetermined, eligibility workers are required to send PGH workers another form only if they decide, based on data contained on the redetermination form, that the family is in need of medical or dental services. The majority (56 percent) of the PGH workers surveyed said that they rarely received referrals at redetermination (See Table V-7).

TABLE V - 6

PROVIDER LISTS MAINTAINED BY PGH WORKERS

A. PRIMARY CARE PROVIDERS ON LISTS

Type of provider	Percent of workers whose list includes each type
Pediatricians	100
General practitioners	100
Other specialties	92
Community health centers	92
Other clinics	82

B. PGH/MEDICAID STATUS OF PROVIDERS ON LISTS

Status	Percent of workers whose list includes each type
PGH providers only	0
PGH providers plus some other medicaid providers	41
All medicaid providers in area	59

C. OTHER MEDICAID PROVIDERS

Type of provider	Percent of workers whose list includes each type
Dentists	100
Pharmacies	33
Outpatient clinics	82
Family planning clinics	67
Visiting nurses	44
Transportation	54
Medical equipment	51
Other	44

TABLE V - 7

PGH REFERRALS FROM FINANCIAL ASSISTANCE WORKERS

A. QUALITY OF PGH REFERRAL FORMS FROM FAWS

Forms complete and accurate, in general	Percent of workers
Yes	46
No	31
Other	15
No answer	8

B. PROMPTNESS OF PGH REFERRALS

	Median days elapsed	Range of days elapsed
Time elapsed between eligibility determination and PGH receipt of referrals	5	0-30

C. REFERRALS AT REDETERMINATION

Frequency of redetermination referrals from FAWS	Percent of workers
Often	15
Sometimes	28
Rarely	56

c. PGH workers had several suggestions for improving the information they receive from eligibility workers. The most common suggestion was to train eligibility workers and other local office staff in the function and importance of the PGH program. As one worker requested:

> When new workers (AFDC) are trained give them enough information about PGH so they will have a working knowledge about the program. I don't believe half of the personnel in our office knows who we are or where we are located and I have the feeling they have not been made aware of us....

Other suggestions included strategies for strengthening the referral process:

- Creating better incentives to encourage eligibility workers to fill out the PGH portion of the application (the two pages which become the PGH referral) completely and accurately. Currently, the performance of the eligibility worker is judged on the financial portion of the application, and not on the PGH referral. Also, eligibility supervisors review only the financial portion of the application to make sure it is complete.

- Requiring eligibility workers as part of the application process to schedule an interview for the client with the PGH worker.

- Requiring eligibility workers to refer all families whose children are not enrolled in PGH to the PGH worker when the families' eligibility is redetermined.

- Allowing PGH workers to place a note in the files of families they would like to have referred at redetermination. The eligibility worker would then be required to refer these families to the PGH worker at the next redetermination.

- Notifying the PGH worker of all redeterminations as they are scheduled so the worker can arrange to be available to see families at the redetermination interview.

- Referring to the PGH worker the files of all families transferred into the office from another local office.

d. PGH administrative staff have noted that new eligibility workers are being trained about PGH. The training efforts do not include present eligibility workers.

2. The forms used to refer eligible children to PGH, particularly the Medical Assistance only forms, do not provide the PGH worker with enough information.

   a. Several PGH workers noted the inadequacy of the referral forms both for new clients and for those having their eligibility redetermined. For example, one worker pointed out that on the Medicaid-only application, clients are asked if they desire information on the services provided by PGH only if they said earlier that they need help in obtaining health care for eligible children under age 21.

      In addition, workers reported that the level of detail requested on the forms is often insufficient. One regional PGH supervisor had a rubber stamp made with spaces for additional information such as social security number and whether an eligible woman was pregnant. She stamped all the blank referral forms used in the local offices in her region, so that the information would be collected during the normal application process.

   b. The Department has contracted with a private firm to design a client and management information system for the Department's financial and medical assistance programs. The proposed Massachusetts Public Assistance Control System (MPACS) will assist the eligibility intake workers in gathering information needed to determine client eligibility; the information on families' current medical care and medical problems will then be relayed by MPACS to PGH workers. The specific data requested from the eligibility worker and the form in which they will be transmitted to the PGH worker are still being developed.

3. PGH field staff believe that the computerized tracking system is cumbersome and does not provide useful reports.

   a. The major purpose of the PGH tracking system is to provide information to the field staff for their use in recruiting eligible children, monitoring the screenings provided and tracking the treatment provided for health problems. The system contains, for example, the names and addresses of eligible children, the names of children assisted by PGH staff and the date of a child's last medical check-up billed to Medicaid. The tracking system is a computerized subsystem of the Medicaid Management Information system (MMIS).

   b. Workers reported spending 5-10 percent of their time entering and updating information in the tracking system. In general they feel that the information they received from the system was not worth the effort they put into it: As one person wrote:

Re: PGH data tracking system: I hope management is getting a tangible benefit from our inputs into it. Several of the computer reports are helpful to PGH Specialists, but most of them are not, and a significant amount of time must be dedicated to "feeding the system."

c. In a meeting held in November 1983, PGH field supervisors suggested changes in the format and categories of data reported in the tracking system that would make the information collected more useful to them. These changes were delayed while the Medical Management Information System was implemented. During implementation, priority was given to Medicaid payment and control systems, rather than to PGH tracking. Now that the conversion to MMIS has been completed, the PGH tracking system improvements could be made.

d. The proposed Massachusetts Public Assistance Control System (MPACS) is intended to be a comprehensive management information system; at its core, it is to be an on-line, interactive system for determining eligibility and monitoring ongoing cases in all assistance programs. Under the design proposal now being reviewed by the Department, MPACS will have a referral function for PGH, but will not include PGH tracking. The system will not record PGH workers' contacts with clients or track the screening or treatment received by clients.

4. <u>The PGH tracking system has serious limitation which prevent a realistic appraisal of the treatment received by clients</u>.

The PGH providers who screen children note on the billing form whether additional treatment is needed and what type of treatment (in one of five broad categories) is required. The names of the children needing treatment are kept on the system until another billing form is received, reporting that the treatment has been given. Children who do not receive the required treatment are contacted by their PGH field worker who provides further assistance.

This system has many problems. The system may decide a child has been treated even when the diagnosis and the treatment do not match. A review of 100 cases on the tracking system in October 10, 1983 revealed that only four children could be determined to have received the appropriate treatment. For the remaining 96, either no treatment showed up on the system, or it was impossible to tell whether the treatment recorded by the system matched the diagnosis. In addition, providers often do not specify what type of treatment is needed or what kind of treatment has been received. The categories themselves may be too broad to be useful.

5. PGH workers often feel that they lack the clerical support and physical resources they need.

a. The aspect of the office environment most often mentioned as a problem was lack of clerical support. PGH technicians can do some of the clerical work, but only 19 offices (out of 31 offices with a resident PGH specialist) have a PGH technician. PGH workers indicated that local offices provide no clerical assistance to the PGH program.

The lack of clerical support leaves workers with less time for recruitment of eligible children for PGH. As one worker noted in response to the survey:

> Much of the work in the program is straight-forward clerical work (i.e. typing, filing). Presently there are no clerks in the PGH Program (except for central office) and PGH is not allowed access to the clerical pools in the local offices, except on very isolated special projects. It would be helpful for both the PGH specialists and the PGH technicians if clerks were hired, or if an agreement could be reached with the local WSO's (Welfare Service Offices) to provide clerical support. In the cases of the urban offices, particularly, lack of clerical support cuts into the amount of time available to outreach clients....

b. Another serious problem is lack of adequate office space for PGH workers and lack of storage for files and materials. One worker provided a dramatic illustration of this problem:

> In (local office A) the PGH-Unit is located on the 3rd floor, with the Medicaid Unit. The AFDC Unit and case records are located in the basement. In (local office B) PGH has never had "space" to work in. We have to use "any empty desk" or the lunch room table. This makes it very difficult to assist clients in person or on the phone when workers are having a break or their lunch. I have been waiting 6 years for a decent, safe file cabinet. I'm filing most of the PGH work in cardboard boxes.

Another worker noted:

> A relatively large proportion of our clients...do not have telephones and the physical space at the office is so limited that "drop ins" are not welcome by Administration.

Other problems with local office conditions noted by PGH workers in the survey included inadequate furniture and office supplies, and insufficient access to computer terminals through which they could get basic information on eligible families.

6. PGH supervisors cannot give field workers day-to-day, onsite supervision

The six PGH field supervisors are responsible for workers in 31 differen local offices; each supervisor has to divide his/her time among several offices. In their responses to the worker survey, PGH specialists reported that their supervisor was in the same office with them an average of 3.25 hours per week. (See Table V-8.)

However, most workers also reported that when problems arose they were able to get in touch with their supervisor within a reasonable period of time. Seventy-four percent of the workers were "often" able to get in touch with their supervisor when needed while 21 percent answered "sometimes" and 5 percent answered "rarely."

IMPLICATIONS

Meeting the Department's FY85 goal of 50,000 new children in PGH will require a refocusing, and perhaps a redefinition, of the roles of PGH field staff. Minimally, workers should be relieved of much of the paperwork that takes up their time. PGH letters and informational materials for newly eligible families should be generated from a central location, leaving field staff time for more effective outreach strategies, such as personal interviews. Until the paperwork is streamlined, the Department should provide more clerical support to PGH field staff, through either the local office structure or the PGH structure.

A systems approach to the PGH paperwork might centralize or eliminate other time-consuming reporting and data verification activities as well. In order to maximize such an approach, the senior PGH staff should work with the Department's systems staff to improve the PGH computerized tracking system. They should begin immediately either to improve the PGH subsystem in MMIS or to include the PGH tracking function in the MPACS design.

Most important in refocusing the field staff role, workers should be held accountable for meeting specific enrollment goals. During the past year, the Department has been successful in meeting other management goals by holding workers accountable for certain outcomes as, for example, placing large numbers of AFDC clients in jobs through the Employment and Training Choices program, and reducing error in the AFDC program by making sure that workers recertified AFDC cases in six months or less. A modest goal of 30 newly enrolled children a month for each PGH specialist would make the workers responsible for a quarter of the enrollment increase needed to meet the Department's FY85 goal of 50,000 new children enrolled.

A more fundamental redefinition of the role of PGH field staff should also be considered. It is clear from the comments of the field staff as well as from independent observations that PGH workers spend a significant amount of time helping clients who are not eligible for PGH. In the course of contacting families with children who are eligible for the program, the worker is often asked for information concerning the health care of other family members. In addition, because the PGH worker is the only person in a local office whose responsibilities include giving information and assistance in health matters, adults often come to the PGH worker for help or are referred to the worker by other local office staff. The PGH workers are thus de facto "health specialists."

TABLE V - 8

PGH SUPERVISION

A. NUMBER OF HOURS SUPERVISOR IS IN SAME OFFICE AS WORKER

	Median hours per week	Range of hours per week
Specialist	3.25	0.5 - 10

B. ABILITY TO GET IN TOUCH WITH SUPERVISOR WHEN PROBLEMS ARISE

Frequency of reasonable access	Percent of workers
Often	74
Sometimes	21
Rarely	5

This function can be quite crucial. For example, recently a PGH worker spent nearly two full days helping a pregnant thirteen year old who had been unable to obtain medical care due to a problem with her Medicaid card. This would not be PGH assistance since assistance with Medicaid cards is not a PGH function.

One option in redefining the role of the PGH worker would be to give official recognition to this type of general health assistance. PGH workers could be designated "health specialists" and assigned tasks consistent with additional Department management goals. These include greater client access to health care, increased enrollment in the Health Connection (a program of coordinated health care), more information on family planning services, as well as increased enrollment in PGH. Like the successful Employment and Training Choices program, the health specialist would offer a client choices: enrollment in PGH for his or her children, family enrollment in a coordinated health program, and an opportunity to learn more about family planning.

The health specialist could be held accountable for enrollment goals in all of the Department's health programs, including but not limited to PGH. The drawback of multiple enrollment goals would be to reduce the amount of time field workers spend on less definable problems of access to Medicaid services. A worker responsible for meeting enrollment goals in PGH and the Health Connection, for example, would be unlikely to spend two days solving a problem for one pregnant teenager. The issue could be addressed, however, by formally allocating a certain portion of the worker's time to general health assistance. This approach is used now in the Department when field staff in other programs are given credit for completing a certain amount of "case maintenance."

Whether or not the role of PGH workers is redefined, the supervision and support of these workers remains an issue. Unlike the ET workers and most of the other workers in a local welfare office, the PGH worker reports not to the office director but to a regional PGH supervisor. While this allows the PGH worker to concentrate on PGH enrollment, it results in a lack of day-to-day supervision and an isolation of the PGH worker from the rest of the office.

Furthermore, PGH is not a local office priority. The area directors are part of the Division of Eligibility Operations while PGH is a Medicaid Division program; and for many years PGH carried the additional baggage of being known as a "do nothing" program. Consequently, in some offices, the PGH workers are largely ignored by other workers; their space and equipment problems are neglected, and their recruitment efforts hindered by incomplete referrals and poor communication with their colleagues.

The Department should consider two options for restructuring the PGH program.

1. The first option would be to create the "choices" model described above by fully replicating the ET approach, i.e., by transferring the PGH workers to the Division of Eligibility Operations and thus fully integrating the workers into the field office structure. The program design, development of materials, recruitment of providers, as well as setting of enrollment goals, would remain in the Medicaid Division.

This option could have the significant drawback of jeopardizing the Federal funding available for the administration of PGH. The Medicaid regulations appear to state that local staff must be supervised by a skilled medical professional (in this case the PGH Director) in order for the state to receive 75 percent Federal Financial Participation in the administrative costs of the program. Legal clarification of this point should be sought before planning to implement this option.

2. The alternate option would be to continue the present PGH field structure but mandate ways to increase the AFDC and MA worker responsibility for PGH referrals and enrollment. For example, financial eligibility workers could be held accountable for the accuracy and completeness of the referrals sent to PGH; they could also be required to set up appointments with a PGH or health specialist at the time of the initial application, or to notify PGH workers of redetermination interviews so they can arrange a PGH interview at the same time. Eligibility supervisors could be required to review the PGH referral part of the application for completeness.

Whichever option is adopted, this increased responsibility of the eligibility workers toward the PGH program makes sense.

CHAPTER VI

PGH AND FAMILY PLANNING SERVICES

In evaluating the PGH administrative structure, this study has examined the question of whether PGH staff could and should play a role in offering family planning services to adolescent clients of the Department of Public Welfare. Since the potential of adolescent pregnancy raises a number of issues related to preventive health care, the evaluation staff, at the Commissioner's suggestion, examined the possibility of strengthening the Department's role in offering family planning services through the PGH program.

Adolescent pregnancy involves serious health risks, both for the young woman and the baby. According to the Department of Public Health, pregnant teenagers are four and a half times as likely not to have prenatal care as older women and, as a result, they are more than one and one half times as likely to have low birthweight babies.

The number of teenage mothers in Massachusetts actually declined between 1970 and 1980. However, during this period the number of school-aged mothers 17 years old and under who were unmarried increased more than 35 percent while unmarried 18-19 year old mothers increased 48 percent. The increase in the number of low birthweight babies has followed the increase in the number of unmarried mothers. In 1983, the most recent year for which data are available, there were 2,345 births in Massachusetts to young women under 18, 89 percent of whom were unmarried.

Although the Massachusetts teenage birth rate of 29.3 per thousand teenage women is low compared to the national rate of 53 per thousand, in several regions of the state the rate is much higher. For example, in Holyoke, the teenage birth rate is 88 per thousand; in Lawrence, it is 84; in Springfield, 66; and in Boston, 58. Nationwide, the largest increase in birth rates is among fourteen and fifteen year old white teenagers: the current birth rate among black fourteen to seventeen years olds is already much higher, almost 67 per thousand births.

The high incidence of teenage pregnancies has serious policy implications for the Department of Public Welfare in addition to the health hazard to low birthweight babies. According to the Department of Public Health analysis of births to women under 18 in 1982, 44 percent were on Medicaid at the time pregnancy was verified. By the time of delivery, 66 percent were on Medicaid. Teenage pregnancy is also related to the length of time families remain on AFDC. According to Barbara Blum, in a June 1984 article in the Missouri Social Services Report titled "Innovative Strategies for State Social Services," most women who go on welfare receive assistance for relatively short periods; more than half stay for less than two years. However, "research...suggests that the teen-age mother is likely to be a long-term welfare recipient...A...high school dropout who had a child as a single parent averages ten years of welfare receipt."

While use of family planning agencies by adolescents is growing, the proportion of sexually active teenagers that receive family planning services is still very small. It has been estimated that more than 190,000 adolescent girls, and a similar number of boys, are sexually active. Yet, according to the Department of Public Health, only 31,000, mostly female, are utilizing the services offered by organized family planning agencies to prevent pregnancies. Although this statistic indicates that three times as many teenagers are utilizing such services as in 1975, it still means that roughly nine out of ten sexually active teenagers are not benefitting from family planning services.

This chapter reviews the constraints affecting the availability of family planning services to Medicaid recipients and then focuses on the currently limited involvement of the Department of Public Welfare in referring clients for family planning services.

FINDINGS AND ISSUES

A. Availability of Family Planning Services

Although the Welfare Department will pay for family planning services for its Medicaid clients, many Medicaid recipients do not have easy access to these services.

1. The geographic distribution of family planning services is uneven statewide, with critical shortages in several areas.

a. The Welfare Department has certified sixty family planning clinics to provide services to Medicaid clients in Massachusetts. The uneven distribution of these clinics however, results in significant gaps in coverage as, for example, the Lynn-Saugus-Melrose area. (See Table VI-1.)

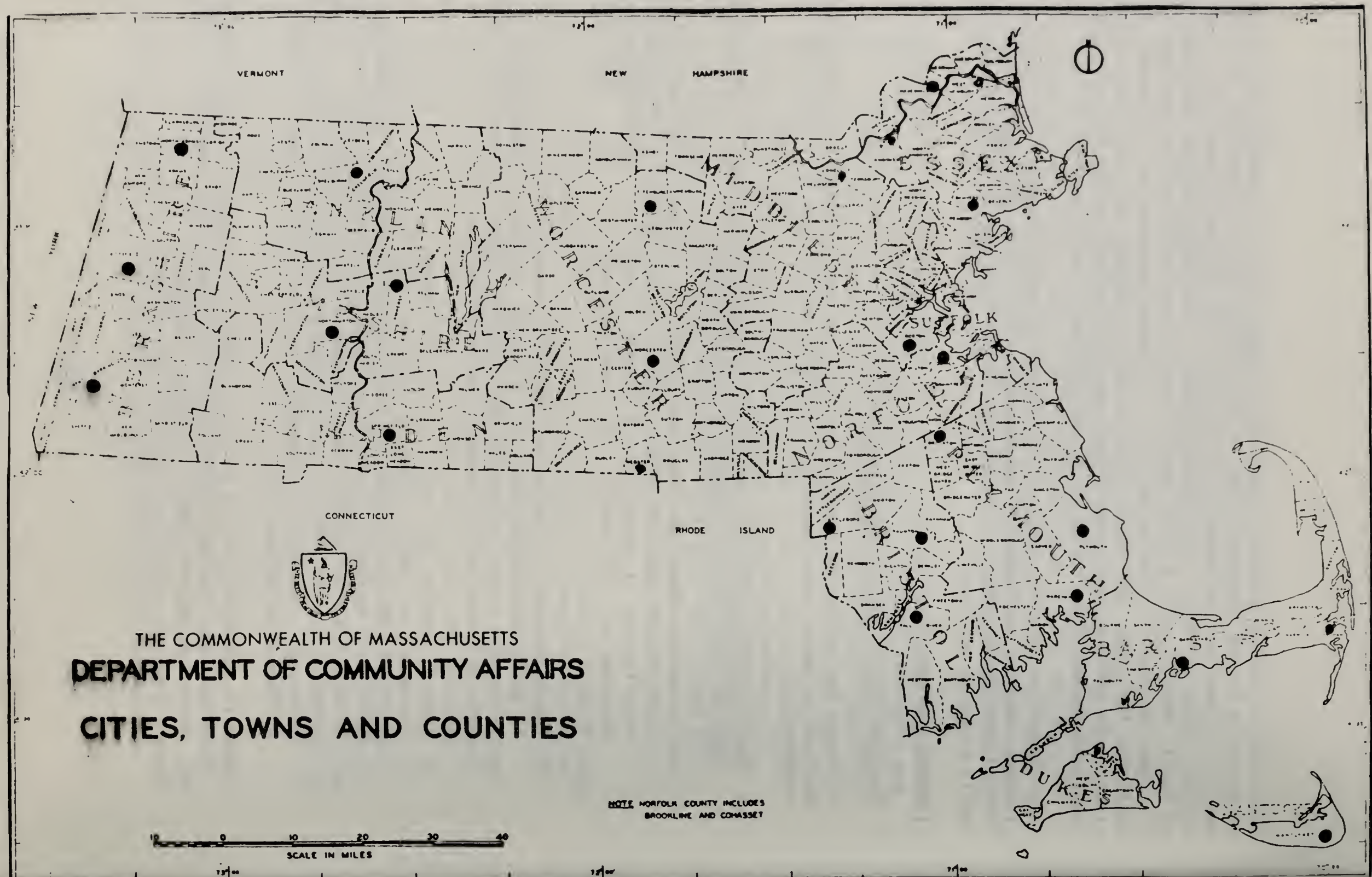
b. The Department of Public Health (DPH) provides family planning services in twelve adolescent pregnancy programs located in twenty-three sites across the state. However, due to limited funding, their services are not available to all teenagers who need them.

c. Federal funding for family planning is being cut back. Federal reimbursement for family planning services is 90 percent, except for abortions which are paid for entirely by the state. The primary source of Federal monies is Title X, which was cut from $3.8 million in 1981 to $3.1 million in 1984 - a reduction of almost 20 percent. In addition, the use of Title X funds is more restricted than it was a few years ago: almost 15 percent of the funds must be spent on Federally-defined priorities.

d. While gynecologists in private practice can provide family planning, many ob-gyns do not accept Medicaid patients, and some areas of the state are experiencing critical shortages.

Table VI-1

DISTRIBUTION OF FAMILY PLANNING CLINICS



The statewide average is about 250 Medicaid patients for each participating ob-gyn, but in Holyoke the ratio of Medicaid clients to participating ob-gyns is 2,356 to one. In this location almost half the births are to women receiving Medicaid, yet only one ob-gyn accepts welfare clients. Other regions experiencing acute shortages include the North Shore, Cape Cod, and Springfield-Chicopee. The Department has made progress in improving this situation but the problem has not been solved completely.

2. Many adolescents who are covered by Medicaid do not utilize the family planning resources available to them due to difficulties they experience (or anticipate experiencing) gaining access to the family Medicaid card.

In order to receive services under Medicaid, recipients must go to a physician or other provider certified by Medicaid, bringing a current Medicaid card to demonstrate eligibility. The overwhelming majority of teenagers covered by Medicaid are dependents in a public assistance household. The adult head of household receives a card each month which covers all eligible household members. As discussed in Chapter IV, the dependent adolescent Medicaid recipient must therefore obtain this card to receive the free medical care he or she is entitled to. For many teenagers, this proves to be an insurmountable obstacle -- and they consequently go without the family planning attention they might otherwise seek.

Two groups of teenage Medicaid-eligible recipients receive Medicaid cards in their own name. First, the head of an AFDC household may herself be under age 21: 18 percent of all teenagers receiving AFDC are heads of households, or from another perspective, 6 percent of all AFDC heads of households are teenagers. Second, a small minority of Medicaid clients, about 2.6 percent of all recipients, are covered under the MA-21 program. This is a Medicaid program for adolescent recipients who are under twenty-one and do not have children of their own. Within this group, those adolescents who do not live with their parents have their own Medicaid cards. These adolescents are free to use their cards as they choose.

3. Programs involving the male adolescent in any aspect of family planning are virtually nonexistent.

Family planning programs are overwhelmingly designed to address women and their needs. Birth control information and contraceptive devices, counseling, and even advertisements which promote family planning, are all basically geared toward women. Significantly, both the staff of family planning agencies and school health officials who try to provide basic family planning information are predominantly women. Also, there are very few programs to support teenage fathers in their roles as parents.

B. Current Department Involvement

The current involvement of the Department of Public Welfare in referring clients for family planning services is minimal. The Department pays for family planning services under Medicaid but has no process for systematically making referrals.

1. There are no formal contacts between local welfare offices and family planning agencies.

   No family planning agencies have been enrolled as PGH providers, although efforts have begun in this area (see Chapter IV). No formal relationships exist between the agencies and welfare service offices. Moreover, although Medicaid provider regulations suggest it, they do not require that the agencies and welfare offices exchange information, even for as basic a service as the provision of family planning literature in welfare office waiting rooms.

2. Current Welfare Department policies and procedures do not encourage involvement in family planning for clients.

   a. In October 1984, the evaluation staff conducted an informal telephone survey of eleven PGH specialists to ascertain their involvement with family planning. The specialists pointed out that the Department has not made this a topic of importance or emphasis, that they have received no training in this area, and that the topic of family planning has rarely been discussed at staff meetings. PGH administrative staff report that there have been presentations on family planning at statewide PGH staff meetings.

      Neither the Department in general nor PGH has any educational family planning brochures. Two-thirds of the PGH specialists and technicians maintain lists of sources of family planning services. But exposure to this information is basically limited to PGH families. The majority of Medicaid clients have no access to it. Even teenagers whose families participate in PGH may not receive family planning information because the PGH specialists work primarily with their parents.

      In the absence of a formal Department position on family planning, involvement by PGH specialists tends to vary widely, depending primarily on the interests of the individual staff member and the importance he or she attaches to the topic. Other factors include the needs of the client population in a given geographical area, and practices in individual offices. In most offices, clients who state on application forms that they are up to date on medical/dental visits are not targeted to be seen by PGH specialists. Thus, many clients do not have the opportunity for in-person counseling on family planning.

   b. In the telephone interviews, the specialists frequently mentioned the shortage of PGH technicians as a problem in attempting to provide comprehensive care for clients. The specialists stated that they have too much clerical work which reduces severely the time permitted them for individual consultations with clients concerning any health matters, certainly including family planning.

c. As discussed in Chapter V, another major problem the PGH specialists identified is the accuracy of information provided to them from the AFDC and Medicaid application forms. For instance, nowhere is it specifically asked who, if anyone, in a household is pregnant.

3. Family planning is rarely discussed in PGH interviews; when the topic is raised by clients it is usually because they are seeking abortions.

a. Requests for family planning services comprise a very small part of PGH assistance. From the worker interviews, these requests range from zero per month, even in offices with exploding teenage pregnancy rates, to approximately 10-15 percent of the assistance provided in two of the offices.

Most PGH specialists interviewed report that the topic of family planning comes up when the client specifically asks for services. Many staff clearly indicated that they never would, nor have, themselves broached the subject. Only two specialists stated that they occasionally initiate the topic. One said, "If I know a client well, I can ask if family planning has been considered..." but she then added that this is most unusual. The other said that she tries to bring up the subject when she feels it may be appropriate, but stops if she senses that this may interfere with the goal of getting the client into regular care.

b. Overwhelmingly, family planning requests come from pregnant women who are seeking abortions. Usually it is the head of the household who is seeking services for herself; occasionally teenage dependents call to obtain birth control services or abortions for themselves. Very rarely will a mother call seeking family planning assistance for her adolescent child.

Among the vast majority of clients seeking services, family planning is equated with obtaining abortions. Requests for preventive care are minimal, consisting primarily of calls for contraceptive devices.

4. Given the current structure of the Project Good Health program, PGH specialists spend very little time with the adolescent dependents in PGH-eligible families.

A very few PGH specialists stated that they make a point of seeing every family member in-person at least once. Most specialists reported that they interview every head of household, but have limited contact with dependents, especially teenagers.

The two groups of adolescents who do receive attention are adolescents pregnant for the first time and teenage heads of household. One specialist identified the provision of basic education to pregnant girls as one of her primary goals.

Dependent adolescents, however, comprise the overwhelming majority of teenagers who receive PGH assistance. This population does not respond to repeated outreach attempts by PGH staff as discussed in Chapter IV. When pressed for percentages, only two specialists indicated that they might spend as much as 10 percent of their time with non-pregnant teenagers who live with family members. Reported contact by most specialists consisted primarily of responding to requests for primary care, as for example, helping to find providers such as dentists and oral surgeons.

IMPLICATIONS

The availability of family planning services to Medicaid clients through either clinics or private physicians across the state of Massachusetts is very broad, although by no means universal; geographic gaps in service and reductions in funding restrict the availability of services to some individuals. It appears, however, that only a small fraction of the Medicaid-eligible adolescent population uses these family planning services.

Provision of information about family planning and the referral to family planning services have only recently become Department of Public Welfare priorities. Thus overall Department strategies to promote preventive tactics such as basic contraceptive education and easy access to birth control devices are virtually non-existent. There are no Welfare Department family planning brochures nor is birth control information contained in PGH literature. Furthermore, the Department has no formal arrangements with family planning agencies to provide their own brochures in PGH mailings or Welfare waiting rooms. Such efforts would be easy and inexpensive to implement, and would promote choice among eligible Medicaid recipients.

The Department's procedures and training limit the involvement of its field staff in family planning. For instance, key forms used by PGH to gather preliminary information about new enrollees fail to identify clients who are pregnant. The Department does not offer training to PGH specialists or other field workers in family planning counseling or information-sharing strategies. Without a formal policy on family planning, and without information or training, PGH specialists and other staff are reluctant to initiate discussions about family planning. They feel family planning is a sensitive subject. As a result, they only talk about family planning when clients ask about it.

The contacts between Department staff and adolescent clients are limited. Most dependent teenagers are rarely seen; they are not responsive to current PGH outreach techniques. Thus the possibility of building a friendly and/or trusting relationship does not exist. Yet such a relationship could be invaluable for an adolescent who needs to discuss family planning issues or seek information that he or she considers to be embarrassing and/or private.

Restricted access to the Medicaid card and concerns over confidentiality are substantial problems which further reduce teenage use of available medical services. Adolescents who are dependents must secure the family Medicaid card to prove current eligibility. For families enrolled in PGH, there is an additional obstacle because the adult head of household receives notification when the teenager is due for her next screening. The type of service provided is not indicated in the notification letter but the head of household will be made aware that PGH services have been received by the teenager. As a consequence, teenagers feel constrained in making decisions regarding their own health care.

Clearly, changes in the Department's policies and field practices are needed to support the new priority given to making family planning services available to Department clients. A broadly promulgated Department position promoting family planning services is the most critical need.

Development of Welfare and/or PGH brochures would provide crucial support, as described in Chapter V, to the new policy, as would appropriate training of PGH and other field staff. Medicaid card access and confidentiality questions need to be resolved. Finally, the development of a new health specialist position that would provide a real staff commitment to family planning by holding staff accountable for informing clients about the availability of these services is essential. These changes require decisions and actions from the Department's senior staff.

CHAPTER VII

RECOMMENDATIONS

The current PGH enrollment of 26 percent of all eligible children is a substantial improvement over the 6 percent enrollment figure used in the Vega suit in 1980. Yet the current enrollment falls short of the Department's goal of 50 percent. The analyses presented in this report indicate that the strategies used up to now to bring families into PGH will not be effective in reaching this goal.

To increase PGH effectiveness, the report has proposed three broad alternative strategies for reaching PGH eligible families:

- To reach families who already have a regular source of medical care, PGH should broaden its recruitment of health care providers.

- To reach families who do not have a regular source of medical care, PGH should first expand its recruitment and service delivery system to include agencies and organizations which are in touch with and accessible to these families.

- Also to reach families without regular medical care, PGH should refocus and possibly redefine the activities of the PGH field staff.

In addition, the report has analyzed the Department's potential role in referring clients for family planning services.

This chapter presents the specific recommendations which follow from the report's analyses.

PROVIDER RECRUITMENT

1. The PGH provider recruitment staff should increase its efforts with physicians who have not previously participated in PGH in large numbers: general and family practitioners, internists, gynecologists and female physicians. Special attention should be paid to geographical areas with service gaps.

2. The Medicaid Provider Relations unit should recruit more pediatricians and other primary care physicians to the Medicaid program in parts of the state where many PGH-eligible families use private physicians but not many physicians participate in Medicaid.

3. PGH recruitment strategies for individual providers should include:

- o personal visits to each physician being approached about participation;

- o the expanded use of professional endorsements and networking by the American Academy of Pediatrics and current PGH providers;

- o informational programs for various physician groups in the state, including information about recent program changes which make PGH participation more attractive, e.g., increased fees, less paperwork, revised forms.

4. The PGH administrators should review the documentation and recordkeeping required of PGH providers to determine if any requirements can be further simplified.

5. PGH administrators should create an ongoing advisory committee of physicians to provide an avenue for communication between physicians and program administrators.

6. PGH provider recruitment efforts should include having PGH specialists target providers to be recruited since the specialists are aware of the medical resources in their areas and have personal contacts with health care providers.

7. The PGH administrators should strengthen the program's ongoing provider relations functions to maximize retention. Consideration should be given to separating the provider recruitment and provider relations functions.

8. Ongoing provider relations should, at a minimum:

   - o provide easy access to Department staff for PGH providers with questions about the program and problems with billing;

   - o support the providers in obtaining timely payments for PGH services; and

   - o provide ongoing training and technical assistance.

9. The PGH staff should conduct periodic reviews of physicians' records as a means of providing technical assistance to providers. The review would not lead to penalties but would be designed to assist physicians in correcting weaknesses in their recordkeeping and documentation.

10. The PGH administrators should continue to recruit community health centers by working with individual centers to alleviate the problems that they presently have with PGH procedures.

11. The Department should examine the feasibility of allowing community health centers that are enrolled as Health Connection sites with the Department to provide summary reports to PGH for all the children who use their centers. New Federal regulations specifically allow those children enrolled in the Health Connection to be claimed on summary reports.

12. The PGH administrators should continue their efforts to enroll independent physicians who practice in outpatient departments of hospitals.

13. The PGH administrators should explore the feasibility of recruiting hospital-licensed community health centers to become PGH providers. The feasibility study should include an analysis of the costs of changing the centers' billing procedures to meet PGH requirements.

14. The Department should develop a system for identifying PGH-eligible children who are enrolled with continuing care providers so that these children can be enrolled in PGH when the new Federal regulations take effect this month.

15. PGH administrators should expand the section of the physician manual which describes the nutritional status assessment to state more explicitly the measures of nutritional status to be used.

16. Children found to be at nutritional risk should be treated or referred to another health professional, such as a nutritionist, for treatment. PGH specialists should develop lists of nutritionists for whom a Medicaid reimbursement mechanism exists to assist physicians in making these referrals.

EXPANSION OF THE RECRUITMENT AND SERVICE DELIVERY SYSTEM

1. The Department should consider establishing a process by which adolescents' Medicaid eligibility can be verified by providers without the need for adolescents to have access to their family Medicaid cards.

2. The PGH administrators should renew their efforts to enroll family planning clinics as PGH providers. PGH staff must first work with representatives of family planning clinics and with the Department's Systems staff to solve the confidentiality and tracking problems before recruiting individual clinics.

3. The PGH administrators should identify and, where appropriate, recruit as PGH providers school systems in Massachusetts which currently offer comprehensive health care to their students.

4. In the Lawrence area, PGH staff should work with the Greater Lawrence Family Health Center to ensure that participants in the Children's Health Project have been transferred to the Family Health Center for PGH services.

5. As a longer range effort, the PGH administrators should work with the Departments of Public Health and Education to consider developing a comprehensive plan for identifying and referring to PGH providers school age children who are not receiving regular health care.

6. The PGH administrators should immediately take steps to include PGH in the WIC special outreach to Southeast Asian refugees.

7. The PGH administrators should develop a plan for awarding small grants to community organizations to do outreach to non-English speaking families. These grants should not duplicate the WIC outreach efforts.

8. The Department should encourage and support the efforts of the Departments

of Social Services, Youth Services, and Mental Health to enroll the children in their custody in PGH.

9. The PGH administrators should develop, and consistent with confidentiality requirements, implement a plan in cooperation with hospitals for enrolling in PGH all Medicaid eligible newborns.

10. The Department should work with officials in the Department of Public Health to add data elements to the high-risk infant identification program that will enable PGH staff to recruit the families of those infants to PGH.

11. The PGH staff should consider contracting with Head Start programs to recruit families to PGH.

12. The PGH staff should continue their work with the DPH preschool health initiative to develop a day care health manual for day care providers and work to inform day care providers about PGH.

13. The PGH staff should continue to negotiate with DPH staff to include the PGH protocol and periodicity schedule in all Public Health contracts with Family Health providers.

14. The Department should consider performance based contracts with other state agencies -- DPH, for example -- to assist in PGH recruiting.

RESTRUCTURING OF STAFF ROLES AND RESPONSIBILITIES

1. The work of the PGH field staff should be refocused by reducing paperwork requirements and by setting and monitoring monthly goals for the number of children to be enrolled by each PGH worker.

2. To support this shift in emphasis, PGH letters and informational materials to all newly eligible families should be sent from the Department's Central Office using the present systems capability.

3. The PGH administrators should examine the current reporting and data verification activities of the field staff to determine whether some of the activities can be eliminated or done centrally.

4. Until the letter writing and data reporting activities are streamlined, the Department should reassign staff as needed to provide more clerical support to the PGH field staff, through either the local office structure or the PGH structure.

5. The Department should seek to vacate the Vega stipulation, or, alternatively, attempt to have the stipulation modified so that the provisions of the stipulation are consistent with those of the new Federal regulations. Among other areas, these changes are needed to give the Department discretion to improve the effectiveness of PGH outreach.

6. PGH field staff should see families with no regular medical care in personal interviews. PGH administrators should work with the Division of Eligibility Operations and the Office of Administration to develop processes for incorporating these interviews into other intake and

redetermination procedures.

- o Among the options which should be considered at intake are: a) having eligibility workers schedule separate interviews for the clients with PGH workers, as is done with the Employment and Training program and b) having clients meet with PGH workers when they come in to have their photographs taken for their food stamp identification cards.

- o The eligibility workers should notify the PGH workers of all redeterminations as they are scheduled so that the PGH worker can arrange to see families who are not in PGH during the same office visit.

An established process for seeing PGH-eligible families in the welfare offices should reduce the PGH workers' need to contact families by telephone.

7. After PGH workers are relieved of major portions of the letter writing and telephoning they are now required to do, the Department should consider designating their positions as "health specialists," in recognition of their important role in providing health information and assistance to the entire Medicaid population. The health specialists' duties could include:

   - o enrolling eligible children in PGH;

   - o recruiting families for the Department's coordinated health program which includes enrollment in health mainentance organizations;

   - o providing information on family planning and making referrals to family planning agencies;

   - o assisting clients in obtaining Medicaid benefits.

8. If there are health specialists, the Department should set specific enrollment goals for the Health Connection and information and referral goals for family planning, as well as PGH goals for each health specialist, and establish a system to monitor worker performance in meeting goals.

9. The health specialists should be given credit in the proposed Professional Accountability System which will measure workers' outputs for the time spent on clients' problems with health care access.

10. The health specialists should participate in a more systematic way in provider recruitment. They should target providers with whom they have had regular contact and who are most likely to participate in PGH; the specialists should make the initial contact with providers, and, if necessary, follow up after the Central Office recruiter has personally interviewed the prospective provider.

11. The Assistant Commissioners for Administration and Budget should consider a job upgrading for the new health specialist.

12. The Commissioner should consider two options for restructuring the PGH program:

    Option 1: Make the Division of Eligibility Operations responsible for the daily supervision of the PGH field staff, thereby integrating the workers fully into the field office structure. Following the ET model, the program design, development of and setting of enroll-ment goals would remain the responsibility of the Medicaid Division.

    Option 2: Continue the present lines of supervision, but mandate ways to increase the AFDC and MA workers' responsibility for PGH referrals and enrollments by:

    - o setting requirements for the intake workers for the completeness, accuracy and timeliness of referrals to the PGH workers at initial application;
    - o creating standards for ongoing workers for referrals of clients at redetermination;
    - o requiring eligibility workers to refer to PGH the files of all families transferred from another welfare office.

    Whichever option is chosen, communication between the eligibility workers and the PGH staff must be improved.

13. The Department should continue to train all newly hired AFDC and MA eligibility workers and begin to train all current AFDC and MA workers in the purpose and function of PGH.

14. The PGH administrators and the Office of Policies and Procedures should revise the AFDC and MA referral forms to PGH to include information needed by PGH workers: social security number, application date, category, whether the application is a new one or a redetermination, and whether an eligible woman is pregnant. The format of the questions on the forms should also be revised so that all applicants are asked whether they want information on PGH.

15. Systems Division should give priority to assisting the PGH administrators to restructure the PGH tracking system so that it can provide the information needed by field workers to identify and track PGH participants in a timely manner.

16. The Department should consider including the PGH tracking function in the planned Massachusetts Public Assistance Control Systems (MPACS).

17. The method used to track children who are found during screening to need additional treatment should be completely revised so that PGH staff can determine whether these children actually receive the treatment they need.

18. The PGH administrators should survey the working conditions of all PGH field staff and submit a request for needed equipment to the Assistant Commissioner for Administration. The Department should provide the equipment needed to make sure that each worker has, at a minimum, a desk

at which to work and a place to store files in each office.

FAMILY PLANNING

1. The Department of Public Welfare should formulate a policy regarding family planning.

2. To support this new policy, the Department should develop family planning brochures appropriate for male and female adolescents and make these available in all welfare office waiting rooms or, alternatively, distribute brochures prepared by family planning agencies.

3. PGH staff should include family planning brochures in all initial PGH outreach mailings.

4. The Department's Training Unit should develop and provide to PGH staff and eligibility workers training relating to family planning -- information about resources, and appropriate interviewing techniques.

5. As recommended above, the Department should develop better relations between the family planning agencies and local welfare offices. Both PGH and eligibility workers should maintain lists of family planning resources, their intake processes, and hours of operation.

6. As recommended above, the Department should consider establishing a process by which adolescents' Medicaid eligibility can be verified by providers without the need for adolescents to have access to their family Medicaid cards.

7. As recommended above, the Department should consider designating PGH field workers as health specialists and formally including referrals for family planning in their duties.

8. The Department should recruit more family planning providers for parts of the state where coverage is inadequate.

9. Medicaid administrators should ensure that the preventive care emphasis in HMO and other coordinated health programs includes family planning services.

LIST OF APPENDICES

APPENDIX A
MEDICAL PROTOCOL AND PERIODICITY SCHEDULE

RECOMMENDED AGE

SCREENING PROCEDURES	New-born	2-6 wks	8-10 wks	4 mos	6 mos	9 mos	1 yr	15 mos	20 mos	2 yrs	30 mos	3 yrs	4 yrs	5 yrs	6 yrs	7 yrs	8 yrs	9 yrs	10-11 yrs	12-13 yrs	14-15 yrs	16-17 yrs	18-19 yrs	20 yrs
Initial history and physical examination	1																							
Discharge history and physical examination	1																							
Health history		2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	
Interval history			1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Comprehensive physical exam		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Developmental assessment		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Nutritional status assessment		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Appropriate immunizations		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Hearing/vision tests (gross)		1	1	1	1	1	1	1	1	1	1	1												
Blood pressure												1	1	1	1	1	1	1	1	1	1	1	1	1
Hearing test (audiometer)														3							3			4
Vision test														3	1		1		1		3			4
PCH education and counseling	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8
Mental and emotional health status assessment																			1	1	1	1	1	1
Pelvic examination																					7	7	1	1
Hematocrit or hemoglobin							2		1											1				
EP or blood lead							1		1		1		1											
TB test							1								4						3			
Urinalysis and/or, if indicated, culture															4			4		3		3		3
Cholesterol-if history indicates														1										
Sickle cell test																				5				
Pap smear																					6	6	1	1
GC culture																					7	7	1	1
Serology																					7	7	1	1

Legend

1. The procedure must be done at this age.
2. The procedure must be done if not done previously.
3. The procedure must be done if not done during the last examination age on the schedule.
4. The procedure must be done if not done during the last two examination ages on the schedule.
5. This procedure should be performed only once and only if indicated by ethnicity.
6. This procedure must be performed if a pelvic examination is performed at this visit.
7. This procedure is optional depending on the maturity level and sexual activity of the recipient.
8. This procedure should be done if appropriate.

Table 9 Number of screenings paid for by state EPSDT programs, by age, 1977

State	Under 1 yr.	1–2 yrs.	2–3 yrs.	3–4 yrs.	4–5 yrs.	5–6 yrs.	Total Screenings, 0–6 yrs.	Total Screenings, 0–20 yrs.
Region I								
Connecticut	5	3	2	2	1	1	14	18
Maine	4	2	1	(1:2 yr.)[a]	.....	(1:3 yr.)	8.33	13
Massachusetts	5	2	1	1	1	1	11	25
New Hampshire	5	2	1	1	1	1	11	15
Rhode Island	once every 18 months						4	12
Vermont	5	2	1	1	(1:3 yr.)	.....	9.67	14
Region II								
New Jersey	1	1	1	1	1	1	6	12
New York	5	2	1	1	(1:2 yr.)	.....	10	13
Region III								
Delaware	1	1	1	1	1	0	5	9
D.C.	2	1	1	1	0	0	5	10
Maryland	2	1	1	1	(1:2 yr.)	.....	6	11
Pennsylvania	5	1	1	(1:2 yr.)	.....	(1:3 yr.)	8.33	14
Virginia	5	3	2	1	(1:2 yr.)	.....	11.5	17
West Virginia	4	2	1	1	1	1	10	16
Region IV								
Alabama	0	0	1	0	1	0	2	6
Florida	1	1	1	1	1	1	6	11
Georgia	3	1	1	0	1	0	6	9
Kentucky	1	1	1	1	1	1	6	21
Mississippi	1	1	1	1	1	1	6	7
North Carolina	4	2	1	1	1	1	10	25
Tennessee	(7:2 yr.)		1	1	1	1	11	12
Region V								
Illinois	4	2	1	1	1	1	10	15
Indiana	1	1	1	1	1	1	6	13
Michigan	2	1	(1:2 yr.)				5	8
Minnesota	2	3	1	(1:2 yr.)			7.5	11
Ohio	1	1	1	1	1	1	6	5[b]
Wisconsin	5	1	1	1	0	1	9	17
Region VI								
Arkansas	1	1	1	1	(1:3 yr.)	.....	4.67	9
Louisiana	3	1	0	1	0	1	6	11
New Mexico	1	1	1	1	1	1	6	12
Oklahoma	1	1	1	1	1	1	6	21
Texas	1	1	1	1	1	1	6	21[c]
Region VII								
Iowa	1	1	1	1	1	1	6	21
Kansas	1	1	1	1	1	1	6	21
Missouri	1	1	1	1	1	1	6	21
Nebraska	1	1	1	1	1	1	6	21

Table 9 (continued)

State	Under 1 yr.	1–2 yrs.	2–3 yrs.	3–4 yrs.	4–5 yrs.	5–6 yrs.	Total Screenings, 0–6 yrs.	Total Screenings, 0–20 yrs.
Region VIII								
Colorado	5	3	2	1	1	1	12	18
Montana	1	1	1	1	1	1	6	21
North Dakota	(1:2 yr.)						3	11
South Dakota	4	2	0	1	1	1	9	13
Utah	1	1	1	1	1	1	6	11
Wyoming	1	0	0	0	(1:3 yr.)	.....	1.67	3
Region IX								
Arizona	No Medicaid Program							
California	5	2	1	1	(1:2 yr.)	.....	10	13
Hawaii	1	1	1	1	1	1	6	12
Nevada	3	1	(1:3 yr.)				5.33	9
Region X								
Alaska	5	2	1	1	1	1	11	19
Idaho	5	2	1	1	(1:2 yr.)	.....	10	15
Oregon	3	1	1	0	1	(1:2 yr.)	6.5	14
Washington	4	1	1	1	1	1	9	25

Sources:
Screenings for children under 6: Community Health Foundation, "A Comparison of Periodicity Schedules and Screening Packages in 50 State EPSDT Programs with Head Start Health Requirements," Evanston, Ill., February 1979 (mimeographed).

Total screenings for children under 21: U.S., Department of Health, Education, and Welfare, "Comparison of EPSDT Program Costs for Present and Mandated Periodicity Schedules," Washington, D.C., HCFA, Office of Child Health, 7 December 1978 (mimeographed).

[a](1:2 yr.) means once every 2 years; (1:3 yr.) means once every 3 years.

[b]The discrepancy between the number of screenings under the age of 6 and the age of 21 result from the information being drawn from two different sources.

[c]Texas was shown as paying for only 11 visits in the HEW source, but interviews with Texas officials in 1978 indicated they would pay for up to 21 visits.

SOURCE:

Foltz, Anne-Marie, An Ounce of Prevention: Child Health Politics under Medicaid, 1982

APPENDIX C

PGH FIELD WORKER SURVEY

On July 1984, the office of Research, Planning and Evaluation surveyed all PGH technicians, specialists and supervisors about their jobs through mailed questionnaires. The response was excellent: 68% of the technicians, 78% of the specialists and 100% of the supervisors returned completed questionnaires.

Attached are the findings from the survey. The first part contains the tables and written synopses of the results of the specialists/technicians survey. The second part contains written synopses of the supervisors survey.

Prepared by:
Office of Research Planning,
and Evaluation

October 10, 1984

SPECIALISTS
AND
TECHNICIANS

TABLE 1

RESPONDENT PROFILE

A. TYPE OF WORKER

Type of worker	Number of respondents	Total number of workers	Response Rate
Specialist	25	32	78%
Technician	13	19	68%
Unknown	1	-	-

B. LENGTH OF TIME AS SPECIALIST OR TECHNICIAN

Type of worker	Median number of years	Range of time
Specialist	3.5	2 months-8 years
Technician	2	2 months-4 years

C. TYPE OF AREA SERVED BY RESPONDENT'S OFFICE

Type of area	Percent of workers
Mainly urban	51
Mainly suburban	26
Mainly rural	8
Urban and rural	3
Suburban and rural	5
All three	8

TABLE 2

ALLOCATION OF PGH WORKER TIME

orker activity	Percent of specialist time	Percent of technician time
oing outreach & assisting PGH ligibles	40	45
ollowing up and tracking PGH articipants	20	20
roviding information and help o clients not eligible for PGH	10	10
ontacting PGH/Medicaid providers, ther than for client	2	0
ocumenting field work in case ecords	15	10
ntering and updating information n computer tracking system	10	5
ther*	4	8

*Includes:

Attending meetings (9 responses)
Performing clerical duties (8 responses)
Consulting with supervisor (3 responses)
Contacting persons in other agencies (2 responses)
Travel (2 responses)

TABLE 3

OUTREACH ACTIVITIES

A. TIME SPENT PER WEEK ON OUTREACH ACTIVITIES

Type of outreach	Median hours spent by specialists	Median hours spent by technicians
Letters	9.0	16.5
Phone calls	15.0	5.0
Office visits	.5	.25
Home visits	.5	.0
Total	25.0	21.75

B. PARTICIPANTS ASSISTED PER HOUR SPENT ON EACH TYPE OF OUTREACH

Type of outreach	Specialist assists per hour of outreach	Technician assists per hour of outreach
Letters	.4	.4
Phone calls	.7	1.4
Office visits	2.0	4.0
Home visits	8.0	-

TABLE 4

CONTACT WITH FAMILIES ALREADY RECEIVING
REGULAR MEDICAL AND DENTAL EXAMS

tent of Contact	Percent of workers
contact beyond initial letter	53
ditional contact with:	
25% of Clients	13
25-49% of clients	3
50-74% of clients	8
75-99% of clients	11
100% of clients	13

WHY MORE CLIENTS DO NOT PARTICIPATE

When asked why more clients do not participate in PGH, the most frequently cited answer was that clients already were receiving regular health care(40% of respondents). Other answers included lack of knowledge about PGH or preventive health care and the enrollment of too few providers.

To increase enrollment, the respondents most frequently recommended increased recipient outreach and preventive health education through face-to-face visits, community organizations, and simplified outreach letters. In addition, PGH training for FAWs and improved communication and cooperation between FAWs and PGH workers were recommended as significant factors which would increase PGH enrollment.

TABLE 5

HELP FOR MEDICAID CLIENTS
(Including PGH-Eligible Client)

SPECIALISTS

Type of help	Frequency of help: Often	Sometimes	Rarely	No Answer
Explaining how to use the Medicaid card	44%	40%	16%	0%
Referring clients to Medicaid providers	96	4	0	0
Giving advice to clients about seeking medical treatment	36	40	24	0
Explaining the Health Connection	24	32	40	4
Referring clients to other services	60	32	8	0
Straightening out problems with Medicaid cards, services, and eligibility	36	32	32	0
Other	20	8	0	72

TECHNICIANS

Type of help				
Explaining how to use the Medicaid card	17%	67%	17%	0%
Referring clients to Medicaid providers	92	8	0	0
Giving advice to clients about seeking medical treatment	36	40	24	0
Explaining the Health Connection	24	32	40	4
Referring clients to other services	60	32	8	0
Straightening out problems with Medicaid cards, services, and eligibility	36	32	32	0
Other	20	8	0	72

TABLE 6

HELP FOR MEDICAID CLIENTS NOT ELIGIBLE FOR PGH

Type of clients	Percent of workers helping each type
Parents of PGH children	100
Other relatives of PGH children	63
Medicaid clients who are disabled	76
Medicaid clients who are 65 or over	68
Other *	26

*SSI Recipients (1)

WIC Recipients (1)

GR Recipients (5)

Pregnant Women (1)

Medicaid Workers (1)

Those Not Yet Eligible for PA (1)

NEED FOR SOMEONE TO PROVIDE GENERAL HEALTH CARE INFORMATION

When asked whether there is a need for someone in the local office to provide general health care information to all Medicaid clients, 80 percent of the respondents answered in the affirmative. The two reasons cited most often for needing health specialists in the local office were to provide preventive health care education and information regarding availability of medical services.

TABLE 7

REFERRALS TO PROVIDERS

Basis for helping client select a provider	Percent of workers
If PGH provider is not provider closest to client, encourage selection of closest provider	62
Encourage selection of PGH provider even if less convenient	30
Depends on situation	8

TABLE 8

PROVIDER LISTS MAINTAINED BY PGH WORKERS

A. PRIMARY CARE PROVIDERS ON LISTS

Type of provider	Percent of workers whose list includes each type
Pediatricians	100
General practitioners	100
Other specialties	92
Community health centers	92
Other clinics	82

B. PGH/MEDICAID STATUS OF PROVIDERS ON LISTS

Status	Percent of workers whose list includes each type
PGH providers only	0
PGH providers plus some other medicaid providers	41
All medicaid providers in area	59

C. OTHER MEDICAID PROVIDERS

Type of provider	Percent of workers whose list includes each type
Dentists	100
Pharmacies	33
Outpatient clinics	82
Family planning clinics	67
Visiting nurses	44
Transportation	54
Medical equipment	51
Other	44

TABLE 9

CONTACTS WITH PROVIDERS

A. PROVIDER CONTACTS PER WEEK

Type of worker	Median Contacts per worker per week
Specialists	3
Technicians	2

B. NATURE OF SPECIALIST CONTACT WITH PROVIDERS

Nature of contact	Frequency of contact: Often	Sometimes	Rarely	No Answer
Making appointment for client	33%	33%	33%	0%
Discussing treatment needs of a client	4	38	58	0
Answering questions about the PGH program	21	46	29	4
Answering questions about PGH claims	17	8	75	0
Informal recruitment of Medicaid	13	42	46	0
Answering questions about other Medicaid programs	4	8	79	8
Other	17	13	4	66

C. NATURE OF TECHNICIAN CONTACT WITH PROVIDERS

Nature of contact	Frequency of contact: Often	Sometimes	Rarely	No Answer
Making appointment for client	8%	46%	46%	0%
Discussing treatment needs of a client	15	23	31	31
Answering questions about the PGH program	46	31	8	15
Answering questions about PGH claims	8	23	46	23
Informal recruitment of Medicaid	8	23	31	38
Answering questions about other Medicaid programs	0	15	46	39
Other	0	0	0	100

WHY MORE MEDICAID PROVIDERS DO NOT PARTICIPATE

Sixty-four percent of the responses to why Medicaid providers do not participate in PGH identified the lag time in receiving payments for medicaid services and the claims process and paperwork as the reasons for nonparticipation in the PGA program. A lesser number of responses (12%) pointed to the problems with the failure of clients to keep their appointments.

TABLE 10

PGH SUPERVISION

A. NUMBER OF HOURS SUPERVISOR IS IN SAME OFFICE AS WORKER

	Median hours per week	Range of hours per week
Specialist	3.25	0.5 - 10

B. ABILITY TO GET IN TOUCH WITH SUPERVISOR WHEN PROBLEMS ARISE

Frequency of reasonable access	Percent of workers
Often	74
Sometimes	21
Rarely	5

TABLE 11

PGH REFERRALS FROM FINANCIAL ASSISTANCE WORKERS

A. QUALITY OF PGH REFERRAL FORMS FROM FAWS

Forms complete and accurate, in general	Percent of workers
Yes	46
No	31
Other	15
No answer	8

B. PROMPTNESS OF PGH REFERRALS

	Median days elapsed	Range of days elapsed
Time elapsed between eligibility determination and PGH receipt of referrals	5	0-30

C. REFERRALS AT REDETERMINATION

Frequency of redetermination referrals from FAWS	Percent of workers
Often	15
Sometimes	28
Rarely	56

ADMINISTRATION AND MANAGEMENT

A. Changes in local office procedures

An increase in PGH training for FAWs and PGH workers was identified most often as the most needed change in local office procedures. Additionally, respondents felt that the accuracy and legibility of information on intake forms needed to be improved.

B. Access to care files, computer terminals, and other sources of information; information on changes in PGH and Medicaid procedure and profiles

The questionnaire asked PGH workers whether they received changes in PGH and Medicaid procedures on a timely basis and whether they had easy access to case files, computer terminals, and other necessary information. An overwhelming majority(97%)answered in the affirmative.

C. Adequacy of training

When asked about the adequacy of training, 57% of the respondents felt that the training opportunities were not adequate. A majority recommended that training sessions in Medicaid and MMIS be conducted.

D. Communication with PGH and Medicaid staff in Central Office

Forty-one percent of the respondents reported that they had problems communicating with PGH Central Office. The major complaint was difficulty in reaching the staff by telephone.

One-third of the PGH workers who responded to the question asking whether they had problems communicating with the Medicaid Central Office staff answered in the affirmative. The respondents indicated that they had problems both in reaching the appropriate staff person on the telephone and in obtaining adequate responses.

E. Changes in current supervisory system

When asked about changes in the current supervisory structure, 66% percent of those who made recommendations suggested that the supervisors' time be reallocated so that more hours could be spent in the local office and that the supervisors could cover smaller areas.

SUPERVISORS

WHY MORE CLIENTS DO NOT PARTICIPATE

The most common responses to the question of why more clients do not participate in PGH were that clients already had a regular doctor(4 responses out of a total of 6 supervisors responding), a lack of PGH providers in the area(3 responses), and an inadequate understanding on the client's part of the value of preventive health care(3 responses).

When asked what changes should be made in the program to get more children enrolled, several of the respondents suggested increasing efforts at outreach and assistance(3 responses), and more training for workers and FAWs(2 responses).

NEED FOR SOMEONE TO PROVIDE GENERAL HEALTH CARE INFORMATION

Five of the six respondents felt that there was a need for someone in the local office to provide general health care information to all Medicaid clients. The other respondent felt that this kind of a person should be located in the Central Office. Respondents felt that providing general information took workers' time away from PGH duties.

WHY MORE MEDICAID PROVIDERS DO NOT PARTICIPATE

Respondents were most likely to think that Medicaid providers did not participate in PGH because it took the providers too long to be reimbursed(4 responses), they had problems with the PGH billing procedures(3 responses), they were afraid of being audited(2 responses), or they disagreed with the PGH protocol and periodicity schedule(2 responses).

ADMINISTRATION AND MANAGEMENT

A. Changes in local office procedures

The changes in local office procedures most commonly suggested to improve the jobs of PGH workers concerned the relationship between PGH workers and other local office workers. Three respondents felt that the process by which FAWs referred clients to PGH should be better utilized and an equal number of respondents thought that all local office staff should be trained or informed about PGH.

B. Information on changes in PGH and Medicaid procedures and policies

Five of the six respondents felt that they were kept informed in a timely manner of changes in current PGH and Medicaid procedures and policies.

C. Communication with PGH and Medicaid staff in Central Office

When asked about problems communicating with PGH staff in the Central Office, 4 respondents said they had some kind of problem in communication. The most common problem mentioned was difficulty in reaching PGH staff by telephone(3 responses).

Three respondents felt they had problems communicating with Medicaid staff in the Central Office. All three mentioned difficulties in finding someone on the Medicaid staff who could give them an answer to a specific question.

D. Changes in current supervisory system

Of the six supervisors responding to the question about changes they would make in the current supervisory system, 2 supervisors felt no changes were necessary. Of the respondents who felt that changes were required, three felt that there should be more supervisors and that each supervisor should be responsible for fewer offices.

TABLE 12

NUMBER OF HOURS SUPERVISOR IS IN SAME OFFICE AS WORKER

Median Hours per week	Range of hours per week
19	5-22½

TABLE 13

SPECIALISTS OR TECHNICIANS ABILITY TO GET IN TOUCH WITH SUPERVISOR WHEN PROBLEMS ARISE

Frequency of reasonable access	Percent of supervisors
Often	100%
Sometimes	0
Rarely	0

OVERALL IMPROVEMENTS IN PGH

When asked what overall improvements could be made in the PGH program that would make it work better, the respondents gave many helpful answers. Two responses stood out, however. Three respondents felt that improvements in the PGH computer system would make the program work better, and an equal number of respondents said that an increase in the number of PGH staff would improve the program.

PGH SPECIALIST/TECHNICIAN SURVEY

The following questionnaire is divided into four broad categories: PGH outreach activities, PGH provider contact, services provided to Medicaid clients not eligible for PGH, and management and procedural issues. We are interested in the types of activities you perform, the time spent on these activities, and your recommendations for methods of increasing PGH participation. Your responses should include both those duties and functions which are part of your formal job description and those informal services which you may provide, such as giving health care information to non-PGH Medicaid clients.

If you need more space to answer a question, continue your answer on the back of the page, and include the question number. Please complete the questionnaire by Friday, August 3, and return it to:

Office of Research, Planning, and Evaluation
Department of Public Welfare
600 Washington Street
Boston, MA 02111

Thank you for your help.

PGH OUTREACH ACTIVITIES

(1) Letters

a. About how much time in an average week do you spend sending out letters to PGH eligibles?

_____

b. In an average month, how many PGH eligibles contact you as a result of these letters?

_____

c. Of the contacts resulting from these letters, how many PGH eligibles do you assist or enroll in an average month?

_____

(2) Telephone Calls

a. About how much time in an average week do you spend making telephone calls to PGH eligibles?

_____

b. In an average week, how many PGH eligibles do you assist or enroll as a result of telephone calls?

_____

3) Office Interviews with PGH Eligibles

a. How many PGH-eligible clients visit you in the office in an average month?

_____

b. About how much time does an average office visit take?

_____

c. How many PGH eligibles do you assist or enroll in a month as a result of these office visits?

_____

4) Home Visits

a. How many PGH-eligible clients do you visit in their home in an average month?

_____

b. About how much time, including travel, does an average home visit take?

_____

c. How many PGH eligibles do you assist or enroll in an average month as a result of home visits?

_____

5) Some PGH eligibles do not request any additional information about PGH and are regularly receiving medical and dental exams. Do you have time to do more than send these clients a letter?

_____

If yes, approximately what percentage of these clients do you have time to contact with more than a letter?

_____

6) What do you think are the reasons more clients in your area do not participate in PGH? Pleast list the most common reasons:

7) What changes, if any, do you think should be made in the PGH program in order to get more children enrolled and using PGH services?

PROVIDER CONTACT

8) We realize you maintain a list of the providers in your area to whom your clients can go for screening services. Does this list include: (Check as many as apply.)

Pediatricians _____

Family/general practitioners _____

Physicians in other specialties _____

Community health centers _____

Other clinics _____

9) What categories of physicians (or clinics) are included? (Check one only.)

PGH physicians only _____

PGH and some Medicaid physicians _____

All Medicaid physicians in the area _____

10) Do you maintain a list of other types of Medicaid providers? (Check as many as apply.)

Dentists _____

Pharmacies _____

Hospital outpatient clinics _____

Family planning clinics _____

Visiting nurses _____

Transportation services _____

Medical equipment suppliers _____

Other (please specify) _____

11) If you were assisting a client by helping him or her to select a physician, and the Medicaid provider closest to him or her did not offer PGH services, which of the following would you do? (Check one only.)

Encourage the client to select the closest provider, even if that provider does not offer PGH services, because you know that the client is more likely to keep the appointment if the provider is convenient to the client _____

Encourage the client to select a PGH provider, even if the PGH provider is in a less convenient location, because it is important that the client receive PGH services _____

12) How many PGH or Medicaid providers do you have contact with in an average week (including letters and calls)?

_____

13) When you are in contact with a provider, what is the usual nature of that contact? (Check the blank that applies in each case below.)

	Often	Sometimes	Rarely
Making appointment for client	_____	_____	_____
Discussing treatment needs of a client	_____	_____	_____
Answering questions about the PGH program	_____	_____	_____
Answering questions about PGH claims	_____	_____	_____
Informal recruitment of Medicaid provider into PGH program	_____	_____	_____
Answering questions about other Medicaid programs such as the Health Connection	_____	_____	_____
Other (please describe)	_____	_____	_____

14) What do you think are the reasons more Medicaid providers do not participate in the PGH program?

HELP FOR NON-PGH ELIGIBLE CLIENTS

15) We know that in the course of doing PGH outreach, many PGH specialists provide information about programs other than PGH and provide help to Medicaid clients who are not eligible for PGH services. Check the blank after each type of service according to how often you are asked to provide it, either to PGH-eligible or non-eligible clients.

	Often	Sometimes	Rarely
Explaining how to use the Medicaid card.	_____	_____	_____
Referring clients to Medicaid providers in the area.	_____	_____	_____
Giving advice to clients on whether they should seek medical treatment.	_____	_____	_____
Explaining the Health Connection programs.	_____	_____	_____
Referring clients to other kinds of services.	_____	_____	_____
Straightening out problems with Medicaid cards, services, and eligibility.	_____	_____	_____
Other (please explain)	_____	_____	_____

16) What kinds of Medicaid clients, other than PGH eligibles, ask for your help for themselves? (Please check all appropriate blanks.)

Parents of PGH children _____

Other relatives of PGH children _____

Medicaid clients who are disabled _____

Medicaid clients who are 65 or over _____

Other (please describe) _____

17) Do you think there is a need for someone in the local office to provide general health care information to all Medicaid clients? If so, please explain.

18) Please estimate what percentage of your time you spend on each of the following activities. (List should total 100%.)

Doing outreach and assisting PGH eligibles _____

Following up and tracking PGH participants and helping them with any problems they may have. _____

Providing information or help to people who are <u>not</u> PGH eligibles (such as family members of PGH eligibles). _____

Contacting PGH or Medicaid providers, and answering providers' questions, when not associated with a specific case. _____

Documenting field work activities in case records. _____

Entering and updating information in the EPSDT tracking system. _____

Other activities. (Please explain) _____

<u>ADMINISTRATIVE QUESTIONS</u>

19) In general, are the PGH referral forms you receive from FAWs complete and accurate?

_____

20) In general, how soon after eligibility is determined do you receive PGH referrals?

_____

21) In general, do FAWs send you PGH referrals when cases are redetermined? (Please check one.)

Often _____

Sometimes _____

Rarely _____

22) Do you have easy access to case files, computer terminals, or other sources of information located in the local office that you need to do your job? If not, please explain.

23) What changes, if any, do you think could be made in local office procedures that would improve your job and its effectiveness?

24) Do you have access to training opportunities similar to those offered to the FAWs in your offices?

25) Are these training opportunities adequate? If not, please give some examples of training sessions in which you would like to participate.

26) Approximately how many hours in an average week is your supervisor in the same office you are?

_____

27) If problems come up when your supervisor is not in your office, are you able to get in touch with your supervisor in a reasonable period of time? (Please check one.)

Often _____

Sometimes _____

Rarely _____

28) What changes, if any, would you make in the current supervisory system?

29) Do you feel that you are you kept informed in a timely manner of changes in current PGH and Medicaid procedures and policies? If not, please explain.

30) Do you have problems communicating with PGH staff located in the Central Office? If yes, please explain.

31) Do you have problems communicating with Medicaid staff located in the Central Office? If yes, please explain.

32) What overall improvements do you think could be made in the PGH program that would make it work better for all people involved?

33) Would you describe the area your office serves as mainly: (Check one.)

Urban _____

Suburban

Rural _____

34) Are you a (check one)

PGH Specialist _____

PGH Technician _____

35) How long have you been a PGH specialist or technician?

_____

36) Finally, what was your last job prior to becoming a PGH specialist or technician?

(Optional) Name and telephone number _____

7/20/84

PGH SUPERVISOR SURVEY

The following questionnaire asks for your opinion of certain aspects of the PGH program. If you need more space to answer any question, please continue your answer on the back of the questionnaire and give the number of the question you are answering. Please complete the questionnaire by Friday, August 3 and return it to:

Office of Research, Planning, and Evaluation
Department of Public Welfare
600 Washington Street
Boston, MA 02111

Thank you for your help.

1) What do you think are the reasons more clients in your area do not use PGH services? Please list the most common reasons:

2) What changes, if any, do you think should be made in the PGH program in order to get more children enrolled and using PGH services?

3) What do you think are the reasons more Medicaid providers do not participate in the PGH program?

4) Do you think there is a need for someone in the local office to provide general health care information to all Medicaid clients? If so, please explain.

5) What changes, if any, do you think could be made in local office procedures that would improve your job and the work of the specialists and technicians you supervise?

✓6) Approximately how many hours in an average week are you in an office with one or more of the specialists and technicians you supervise?

_____

✓7) If one of the specialists or technicians you supervise has a problem when you are not in the office with them, are they able to get in touch with you in a reasonable period of time? (Please check one)

Often _____

Sometimes _____

Rarely _____

8) What changes, if any, would you make in the current supervisory system?

9) Do you feel that you are kept informed in a timely manner of changes in current PGH and Medicaid procedures and policies? If not, please explain.

10) Do you have problems communicating with PGH staff located in the Central Office? If yes, please explain.

11) Do you have problems communicating with Medicaid staff located in the Central Office? If yes, please explain.

12) What overall improvements do you think could be made in the PGH program that would make it work better for all people involved?

13) Finally, what was your last job prior to becoming a PGH supervisor?

(Optional) Name and telephone number _____

7/20/84

The Commonwealth of Massachusetts
Executive Office of Human Services
Department of Public Welfare
600 Washington Street, Boston 02111

CHARLES M. ATKINS
Commissioner

To: Marketing Group

From: Carol VanDeusen Lukas, Director of Evaluation,
Office of Research, Planning and Evaluation

Date: 30 July 1984

Re: Survey Results

In mid-May, a survey research firm, Harrison and Goldberg, Inc. of Boston, conducted a telephone survey of 400 AFDC recipients for the Department. The survey asked about knowledge of and participation in Employment and Training, Project Good Health and to a lesser extent, Food Stamps. It also included several background questions. A copy of the questionnaire is attached. This memo presents the first analysis of the survey results. Research, Planning and Evaluation staff will continue to examine the data: If there are additional analyses in which you are particularly interested, please let me know.

The memo is organized in five sections:

- o Survey Results
- o Overview of Opinion
- o Employment and Training
- o Project Good Health
- o Food Stamps

Each section contains a brief description of the findings, a set of tables with more details, and preliminary recommendations for outreach efforts.

1. Survey Sample

The sample of AFDC recipients was drawn to represent all welfare offices in proportion to their AFDC caseloads. Table A-1 shows that the demographics of the people who completed the survey closely match the Department's data on the full AFDC caseload in terms of race and sex as well as geographic distribution. These data and the program participation-data described below give us confidence that the survey findings accurately reflect the opinions and practices of AFDC clients. At the same time, Harrison and Goldberg point out that interpretations of survey findings should be based on the trends they indicate, not on the exact percentages.

Table A-2 shows additional demographic data not generally available on AFDC recipients: Well over half of the people surveyed report that they are at least high school graduates. Over half of the respondents pay for their own private housing. Over half of the respondents are registered to vote. In the general population about three-quarters are registered to vote.

Table A-3 provides information intended to guide decisions about mass marketing. Statewide, less than one-third of the respondents report that they use public transportation regularly. Not surprisingly this figure varies by geographic area: 57% of the respondents in Boston, for example, regularly use public transportation but only 16% of the respondents in New Bedford do. Statewide, 60% of the respondents regularly listen to the radio. The highest percentages of regular listeners are in Springfield and New Bedford. These findings suggest that the use of public transportation and radio in marketing Department of Public Welfare programs will be most effective if the efforts are targeted to certain parts of the state.

2. Overview of Opinions

Table A-4 provides an overview of the respondents' knowledge and opinion of the Department, its caseworkers and several of its programs. Overall the opinions are favorable:

- The majority of respondents have a high opinion of the Department and of DPW caseworkers in general. To provide a benchmark for interpreting the image of DPW, the survey asked about the Department of Social Services.

- Medicaid has the strongest positive image with 86% of the respondents reporting high opinions.

- Of the people who have heard about PGH, a substantial majority have a high opinion of the program.

- The Department needs to continue its efforts to tell AFDC recipients about ET: 62% of the respondents had never heard of ET and more have not heard of Choices or WTP.

Table A-1

SURVEY DEMOGRAPHICS-I

Geographic Region	Total Caseload*	Survey Sample
Boston	22%	22%
Lawrence	19	19
New Bedford	18	18
Springfield	18	19
Worcester	11	11
Greater Boston	11	11
Sex		
Male	4%	6%
Female	96	94
Race		
White	67%	68%
Black	17	14
Hispanic	15	15
Other	<1	3

* Data taken from Department Records

Table A-2

SURVEY DEMOGRAPHICS-II

Education	
Less than 8th grade	8%
8th grade graduate	29
High school graduate	27
Post high school	35
Housing	
Private	58%
Public	15
Other subsidized	25
Voter Registration	
Registered in Massadusetts	52%
Registered outside Massachuseets	3
Not Registered	45

Table A-3

MARKET INFORMATION BY GEOGRAPHIC REGION

Use Public Transportation

Geographic Region	Regularly	Occasionally	Almost Never
Boston	57%	29%	14%
Springfield	29	20	51
Worcester	20	16	59
Lawrence	24	22	53
Greater Boston	29	24	48
New Bedford	16	16	69
Total	31	22	47

Listen to Radio

Geographic Region	Regularly	Occasionally	Almost Never
Boston	55%	31%	13%
Springfield	74	20	7
Worcester	57	34	9
Lawrence	51	34	15
Greater Boston	57	29	10
New Bedford	64	29	7
Total	60	29	10

Table A-4

CLIENT OPINION

	High opinion	Low opinion	Heard of but no opinion	Never heard of
Mass. DPW	62%	32%	4%	2%
Welfare Caseworkers	57	36	6	2
ET	23	5	10	62
Choices	17	2	11	70
WTP	13	6	4	77
Medicaid	86	10	3	2
PGH	54	6	17	24
Mass. DSS	54	18	18	10

4. Project Good Health

Tables C-1 to C-6 present the major survey findings for PGH. Statewide, 19% of the respondents report that their families are "now using the services offered by Project Good Health." This figure is close to Department data on PGH enrollment.

The survey questions related to PGH focus on family health practices as well as direct participation in PGH. The findings suggest that preventive health care issues for AFDC families are broader than the current PGH focus:

- The majority of respondents-- including those not enrolled in PGH-- report that they take their children "to the doctor for check-ups even when they are well" rather than "hold off and take them to the doctor only when they are sick." As would be expected, the figure is highest for children under 6 (92%) and lowest for children above 14 (59%). (Table C-1)

- Unlike ET, lack of knowledge about PGH does not seem to be a major barrier to enrollment: statewide, 74% of the respondents have heard about PGH. (Table C-2) When asked to describe PGH, respondents gave roughly appropriate answers (e.g. annual immunizations) without prompting-- indicating that they really had heard of the services.

- Respondents most often heard about PGH in a letter from the program (46%) or from a welfare caseworker (24%). (Table C-3)

- PGH enrollment is highest in areas where a high proportion of respondents use private family doctors as their usual source of care for their children. For example in the New Bedford area, where Department data show that 31% of the MA-eligible families are enrolled in PGH, the survey shows that 73% of the families use private doctors. Conversely in Boston, with PGH enrollment of 3%, only 15% of the respondents take their children to private doctors. (Table C-5)

- Many respondents take their children for medical care to community health centers and hospital clinics. Statewide, 23% of the respondents usually go to community health centers and 18% usually go to hospital clinics. (Table C-6)

- Patterns of usual source of care vary sharply in different parts of the state. (Table C-6)

Table C-1

PGH: ENROLLMENT AND MEDICAL CARE BY AGE

Children	Percent of Families enrolled in PGH	Percent of families who take children to doctor when well
Under 6	19%	92%
6-14	22	80
15-20	18	59
Respondent		
18-20	NA	66

Table C-2

PGH KNOWLEDGE V. ENROLLMENT

Geographic Region	Percent who've heard of PGH	Percent Enrolled*
Boston	60%	3%
Springfield	83	24
Worcester	77	20
Lawrence	68	22
Greater Boston	83	17
New Bedford	81	31
Total	74	20

*Department records, not survey data

Table C-3

HOW HEARD ABOUT PGH

(N=290)

Letter from PGH	46%
Welfare caseworker	24
Other	16
Brochure	14
PGH worker	6
Friend/relative/acquaintance	5
Doctor or doctor's office	5
Day care or head start center	3
Newspaper/radio/television	3
DK/NA	1

Table C-4

PGH POINTS WHICH STAND OUT

Regular check-ups	17%
Get reminder, schedule future appointments	14
Ways to get regular medical check-ups	8
Children have chance of staying healthy	8
Helps make some children get good food	7
Way to get regular dental check-ups for children	6
Get help making medical appointments	4

Table C-5

PRIVATE DOCTOR V. ENROLLMENT

Geographic region	Percent using a private doctor	Percent Enrolled in PGH*
Boston	15%	3%
Springfield	71	24
Worcester	59	20
Lawrence	67	22
Greater Boston	67	17
New Bedford	73	31

*Department records, not survey data

Table C-6

USUAL SOURCE OF CARE

Geographic Region	Private Doctor	CHC	Hospital Emergency	Hospital Clinic	Other
Boston	15%	47%	12%	33%	12%
Springfield	71	17	8	12	5
Worcester	59	25	9	16	7
Lawrence	67	19	15	14	6
Greater Boston	67	15	5	20	0
New Bedford	73	10	4	13	12
Total	57	23	9	18	7

These findings suggest that:

1. Clients should continue to be informed about PGH through direct mailings and by local office staff--but a lack of information among clients does not appear to be a major barrier to PGH enrollment.

2. The major PGH outreach efforts should be directed toward drawing new categories of providers into the programs: in addition to recruiting individual physicians, PGH staff should attempt to enroll neighborhood health centers and hospitals clinics. Clearly this is not purely a marketing issue but requires the resolution of signifcant administrative and reimbursement issues first. If those issues can be resolved, PGH staff should contact these providers personally, using brochures and other written materials simply to support those contacts.

APPENDIX E

PGH SPECIAL OUTREACH UNIT ACTIVITY REPORT

TABLE #1

ELIGIBLE CASES UNABLE TO CONTACT

Local Office Name	Total Number eligible cases in local office	Reasons Unable to contact: Language Barrier	Case files not available	No Phone	Wrong Number; no listing; disconnected	Case closed; moved; ineligible category	Unsuccessful phone attempt; No answer; unable to reach left message	Total cases unable to contact	Percent of cases unable to contact
Waltham	835		80	30	150	15	294	569	68%
Brookline	1403	248	250	40	150	35	200	923	66%
Somerville	1696		274	153	304	21	363	1115	66%
Wakefield	542		83	62	84	11	123	363	67%

PGH SPECIAL OUTREACH UNIT ACTIVITY REPORT

TABLE #2
ELIGIBLE CASES REACHED

Local Office	Number of Cases reached	Number of Families Assisted	Families assisted as percent of Number reached	Total Eligible
Waltham	266	63	23.7%	7.5%
Brookline	480	85	17.7%	6.1%
Somerville	581	73	12.6%	4.3%
Wakefield	179	25	14.0%	4.6%

APPENDIX F

Interviews with Physicians

As part of the evaluation of Project Good Health (PGH), the Office of Research, Planning, and Evaluation conducted interviews with a number of physicians participating in the Medicaid program. The purpose of the interviews was to find out why more Medicaid physicians do not offer PGH services.

Fourteen physicians were interviewed, ten of whom offered PGH services and four of whom did not. All those interviewed were pediatricians. Among those interviewed was at least one physician from each geographic region of the state. The names of the physicians who participated in the survey are listed at the end of this report.

The interviews were conducted during the month of May 1984. Most interviews were conducted in the physician's office, while a few took place over the telephone. Each interview began with a standard set of open-ended questions (a copy of which is included at the end of the report), but the final content of the interviews was mainly shaped by the physician's interests and concerns.

The physicians who were interviewed were selected from a list, suggested by a representative of the Massachusetts Chapter of the American Academy of Pediatrics, of physicians who would be aware of the views of other physicians in their communities. Therefore, the physicians interviewed tended to have been in practice for a fairly long period of time and to be established members of their profession.

Results

Initially, several issues were identified as possible reasons for low participation in PGH among Medicaid physicians. In the course of the interviews, the physicians themselves pointed out additional issues that caused them concern. All the issues identified are discussed in this report.

Audits

The issue that caused the most concern among the PGH physicians interviewed was their difficulties in connection with audits. Even those physicians who had not been audited had heard enough from their colleagues to cause them to have strong feelings about the process.

Audits can be more difficult for PGH physicians than for other Medicaid physicians. Unlike most Medicaid services, the PGH protocol includes specific tests and assessments that the physician must provide in order to be reimbursed the additional amount for a PGH screen. In order to justify this additional reimbursement, the PGH physician is required to provide more documentation for PGH services than is required for other types of Medicaid services. Many of the PGH physicians felt that they had not been adequately informed when they began providing PGH services of the documentation they would be required to provide.

Audits were frequently brought up by physicians as a problem in response to general questions about PGH. Three of the ten PGH physicians mentioned audits in connection with changes they would like to see in the program. Two PGH physicians identified audit problems as a reason other Medicaid physicians do not offer PGH services, as did one of the four non-PGH physicians. Three other physicians brought up audits in general discussion.

The physicians interviewed also had a number of suggestions to reduce their difficulties with the audit process. One PGH physician suggested a working group made up of physicians and state auditors to work out explicit standards and procedures for audits. Another physician felt that reviews of physicians' records carried out by PGH staff would be very helpful in informing physicians about weaknesses in their recordkeeping practices before they were audited. Suggestions concerning more explicit documentation standards were made by several physicians.

Paperwork and billing procedures

Among some of the Medicaid physicians interviewed, PGH paperwork and billing procedures, including slow payments, were the major problem they had with the program.

Not surprisingly, given the recent problems with the MMIS computer system, the PGH physicians saw slow payments as the most significant problem in this category. Even aside from the recent MMIS problems, however, nearly all the physicans complained of chronic difficulties being reimbursed in a timely manner for their services. One physician interviewed usually carries several thousand dollars in overdue Medicaid payments on his books at any point.

Slow payments were also mentioned as a reason other Medicaid physicians do not offer PGH services. At least one physician felt that PGH payments were slower than reimbursements for other Medicaid services.

The other major problem in this category was the amount of time, both the physician's time and the billing clerk's time, it took to complete the PGH forms. One physician reported that although PGH participants made up only about one-fifth of his patients, nearly all of his bookkeeper's time was taken up with PGH and Medicaid problems. Several physicians mentioned that the amount of paperwork involved in PGH and the time it required made it much more expensive for them to give a PGH examination than a regular well-child examination.

Three of the ten PGH physicians felt that concern about the paperwork involved is what keeps many other Medicaid physicians from offering PGH services. Of the four non-PGH physicians interviewed, two of the three who had heard of the program specifically mentioned paperwork as the reason they did not offer PGH services. The one non-PGH physician who had not heard of PGH had apparently received information on the program, but his clerk had discarded the informantion without showing it to him because she felt that Medicaid was more trouble than it was worth and she did not want any more involvement with the program.

Other related issues the PGH physicians felt were minor problems were requests for payment being denied, and having to wait up to 30 days for test results before a billing form could be submitted.

Communication

The PGH physicians also identified communication with PGH and Medicaid as a problem, both communication in the provision of information from the program to the physicians, and communication in the willingness of PGH to accept suggestions from the physicians.

Four of the PGH physicians stated that they had had serious difficulties obtaining assistance from Medicaid or from Systems Development Corporation (SDC), the contractor who operates the MMIS system. The physicians and their billing clerks had problems both in reaching Medicaid and SDC by telephone and in finding someone to answer their questions once they got through.

When asked why other Medicaid physicians do not offer PGH services, two of the PGH physicians mentioned the lack of response by PGH to their comments and suggestions. Other physicians spoke in general of unresponsive bureaucracies or what they felt was a general distrust of physicians by Medicaid staff.

Several physicians had suggestions for improving communication between themselves and PGH. Two suggested an advisory committee of physicians to assist PGH with medical issues. One physician felt that PGH needed a formal link to the Massachusetts Chapter of the American Academy of Pediatrics. Another suggested a physician employed as a medical advisor on the PGH staff.

PGH protocol

Generally, the physicians interviewed did not have major problems with the PGH protocol. Five of the ten PGH physicians felt that no changes were needed in the protocol and that PGH physicians should be required to follow all the items in the protocol.

The other five physicians interviewed had suggestions for changes in the protocol. Two felt that annual examinations should be required, even for adolescents, and two thought that the protocol should not require physicians to repeat tests already given in the schools, such as vision and hearing tests. One physician felt that the periodicity schedule should be more flexible to allow deviations in the ages at which examinations are given. Other physicians suggested specific changes in the tests given to children at certain ages.

A more significant problem than the items in the protocol was the documentation the physician is required to keep to show that all items in the protocol have been covered. Some of the physicians interviewed felt the required documentation was too extensive, some wanted to be able to keep their records in a different format, and some thought that PGH should be more explicit and detailed about what documentation is required.

Fees

With the recent increase to a fee of $40 for a PGH screen, the amount of the fee did not seem to be a problem. When the PGH physicians were asked if the fee were adequate, only one physician said no. Four of the PGH physicians said that the fee was adequate, and three felt it was more than adequate. (Two of the ten PGH physicians did not discuss this question.) One physician noted that his problem was with the timliness, not the amount, of the fee. Problems with

the amount of the fee were not mentioned in response to any other question.

Volume of Medicaid patients

On average, the physicians who offered PGH services had a higher proportion of Medicaid patients than the physicians who did not. For the ten PGH physicians, the median proportion of their patients who had Medicaid coverage was 32.5 percent, with a range of 5 percent to 65 percent. The median for the four non-PGH physicians was 7.5 percent of their patients having Medicaid coverage, with a range of 5 percent to 15 percent.

Other physician concerns

One PGH physician expressed concern about the monitoring of children with health problems by PGH. He felt that the existing system was inadequate and that this placed an additional responsibility on the physician.

Two physicians mentioned problems being reimbursed for the care of newborn children whose parents did not promptly apply for Medicaid in the child's name. Changes in Medicaid rules since the interviews took place should have greatly alleviated this problem.

In addition, one of the PGH physicians interviewed was very positive about the program. This physician felt that the additional work involved was negligible, and had adopted the PGH protocol and recordkeeping standards for all her patients. She found the extra reimbursement for the PGH screen very helpful and had been able to replace some old equipment in her office since she had begun offering PGH services.

Recruiting methods

As part of the interview, the PGH physicians were asked how they heard about PGH and what strategies they thought would be effective in persuading other physicians to offer PGH services. The non-PGH physicians were asked if they had heard of PGH, and if so, how they had heard about the program.

Of the four non-PGH physicians interviewed, three had heard about PGH. One had previously offered PGH services, and the others could not specifically identify where they had heard about the program. The fourth had received information about PGH in the mail, but his clerical staff had discarded the information because of bad experiences with Medicaid.

Among the ten PGH physicians, the largest number (four) had started offering PGH services because of an endorsement by the Massachusetts Chapter of the American Academy of Pediatrics or because of a recommendation by a colleague or a business associate. (In one of these cases, the recommendation came from the physician's billing service.) Two of the physicians interviewed had been involved in setting up the PGH program, and one had begun offering PGH services when he was contacted by PGH recruitment staff. The remaining three physicians could not be sure how they had first heard about PGH.

Two of the PGH physicians felt that many other Medicaid physicians simply did not know about the program. Another felt that other physicians might know about PGH but might be unaware of changes in the program to simplify the paperwork.

When asked about changes in the program that might attract more physicians, three PGH physicians mentioned better training and orientation of both new PGH physicians and their staffs. One felt that the provider manual should be simplified and made easier to use.

Specific recruitment strategies were suggested by many of the physicians interviewed. Two physicians each suggested more visits by PGH recruitment staff and more contact from other physicians. Three felt that notices to physicians in Medicaid payments, or notices placed in professional journals or newsletters, would be effective. Informational programs sponsored by the Massachusetts Chapter of the American Academy of Pediatrics or the New England Pediatric Society were suggested by three physicians.

Summary

The results of these interviews suggest that the problems with PGH which are of the most concern to the physicians are audits, PGH paperwork and billing procedures, and communication between PGH and the physicians.

Audits seems to be the area which causes the greatest negative feeling toward the program, both among physicians who have been audited and among those who have gotten reports of audits from their colleagues. Some of the physicians feel that they are not adequately informed of what records they must keep when they begin to offer PGH services.

Among paperwork and billing procedures, the areas most frequently mentioned as problems were slow payments and the amount of time taken up filling out PGH forms.

Reaching Medicaid staff for information and answers to questions was difficult for many of the physicians interviewed and their staffs. Also mentioned as a communication problem was a perceived lack of responsiveness on the part of PGH and Medicaid staff to the physicians' suggestions and comments.

The physicians had several suggestions for actions which would alleviate their concerns about these areas.

Of less concern among the physicians interviewed was the PGH protocol. Most of the difficulties with the protocol appeared to be problems with documentation rather than with the specific items in the protocol.

Only one of the physicians interviewed felt that the amount of the fee for PGH services was not adequate. Timliness in the receipt of the funds was a major source of problems, however.

On average, those physicians interviewed who offered PGH services had a higher proportion of their patients covered by Medicaid than did those physicians interviewed who did not offer PGH services. This indicates that the volume of Medicaid patients a physician sees does have an impact on the physician's liklihood of offering PGH services.

The interviewed physicians also had a number of suggestions for recruiting their colleagues to offer PGH services.

Physicians who participated in the interviews

PGH physicians

Edward N. Bailey, M.D.
Springfield, MA

Cyril Bergman, M.D.
Fitchbrug, MA

Sidney Brodie, M.D.
Brookline, MA

Gerald W. Hazard, M.D.
Hyannis, MA

Elizabeth MacDonald, M.D.
Lynn, MA

David Maltz, M.D.
Cohasset, MA

Edward A. Penn, M.D.
Fall River, MA

Sandy Pitelli, M.D.
Harvard, MA

George Porter, M.D.
Pittsfield, MA

Robert Younes, M.D.
Boston, MA

Non-PGH physicians

Arnold Gurwitz, M.D.
Worcester, MA

John Hubbell, M.D.
Boston, MA

Pat Moffatt, M.D.
Auburndale, MA

William Winter, M.D.
Dedham, MA

For Medicaid physicians currently or formerly providing PGH services

1. Approximately what percentage of your patients have Medicaid cards?

2. To approximately what percentage of your Medicaid patients under age 21 do you provide Project Good Health screening examinations?
If less than 100%, why?

3. How did you arrive at your decision to provide services under Project Good Health? How did you hear about the program? What aspect of the program seemed most attractive?

4. How does the required Project Good Health protocol of tests and assessments and periodicity schedule compare to what you would normally provide in a routine examination to children of different ages? What procedures should be added or not required?

5. If there were more flexibility in the required protocol and periodicity schedule, do you think this would affect the number of physicians providing Project Good Health services?
How much flexibility should be allowed?

6. Please tell me whether, in your experience, the following are major problems with Project Good Health, minor problems, or no problem:

   Having to fill out a different billing form for Project Good Health than for other Medicaid services?

   The time it takes to fill out the Project Good Health billing form?

   The kinds of questions you have to answer on the billing form?

   Your requests for payment being denied because the billing form is not filled out correctly?

   Having to wait up to 30 days for test results before you can send in the request for payment?

   Delays in payment after billing form submitted (other than the recent delays caused by computer system problems)?

7. Are you aware that the fee for a Project Good Health screening examination is now $40.00? Do you feel that this is an adequate reimbursement for this service?

5. If there were more flexibility in the required protocol and periodicity schedule, do you think this would affect the number of physicians providing Project Good Health services?
How much flexibility should be allowed?

6. Please tell me whether,in your experience, the following are major problems with Project Good Health, minor problems, or no problem:

   Having to fill out a different billing form for Project Good Health than for other Medicaid services?

   The time it takes to fill out the Project Good Health billing form?

   The kinds of questions you have to answer on the billing form?

   Your requests for payment being denied because the billing form is not filled out correctly?

   Having to wait up to 30 days for test results before you can send in the request for payment?

   Delays in payment after billing form submitted (other than the recent delays caused by computer system problems)?

7. Are you aware that the fee for a Project Good Health screening examination is now $40.00? Do you feel that this is an adequate reimbursement for this service?

8. What is the major reason you think other physicians do not provide Project Good Health services? Are there additional reasons?

9. Do you feel that the physician's point of view is adequately represented in policy decisions made by the state about Project Good Health? If not, what could be done to be sure this point of view would be represented?

10. In your opinion, what is the most important change that should be made in Project Good Health?

11. (Optional if time remains)
What strategies would you suggest for persuading other physicians to participate in Project Good Health?

For Medicaid physicians not providing PGH services

1. Approximately what percentage of your patients have Medicaid cards?

2. Do you know about Project Good Health?

If no to question #2

3. The purpose of Project Good Health is to provide routine preventive medical care to children under 21 who are recipients of Medicaid. Physicians who accept Medicaid payments may also provide Project Good Health services. Under Project Good Health, physicians are asked to provide a specified protocol of assessments and tests for children of specified ages. The fee for a Project Good Health screening examination is now $40.00. Knowing this, do you think you might be interested in providing these services? (I am not asking you to make a commitment now, but I will ask someone from the Project Good Health office to contact you with more information.)

4. If not interested in providing these services, what is the most important reason?

If yes to question #2

5. How did you find out about it?

6. Did anyone from the state or local office of Project Good Health ever contact you about the program?

7. As you understand it, how does the program work?

8. Do you feel you have enough information about the program?

9. What is the most important reason you decided not to participate in the program? Are there additional reasons?

APPENDIX G

Outreach in Other States

In an informal survey of 10 states, the evaluation staff found that the client outreach efforts conducted by most of the states are generally limited to the procedures mandated by the Federal regulations. However, the states of New York, California and Missouri have implemented special innovative recruitment activities. None of the states have data which can be used to evaluate the effectiveness of these activities, however.

A. New York

The EPSDT program in New York is administered by the Department of Social Services on a county basis. Although the overall statewide participation rate is low, Chemung County, through a contract with the Rural Community Action Group, has particularly innovative outreach methods which include:

1. Infant Registry: Mothers of newborn babies are visited in local hospitals at which time they are notified of EPSDT and 80 to 90 percent enroll. Through this parent contact, older children in the family are also enrolled in the program.

2. Community Agencies and Contacts: Early childhood programs and area pediatricians refer children to EPSDT. Efforts are made to maintain close contacts with local programs that can be of assistance in providing referrals.

3. Pre-School Programs: The EPSDT program in Chemung County has agreements with all pre-school programs, including private nursery schools, the Head Start program, and Elmira City School District's Pre-K program, to receive referrals for EPSDT enrollment.

Statewide, New York had a problem with recruiting providers for the EPSDT program. The major provider complaint was the complexity of the claim form. As a result New York now uses the general Medicaid claim form for EPSDT claims.

B. Missouri

In an effort to reach the teenage population, Missouri developed a statewide cooperative plan between the EPSDT program and the Department of Labor's job training program for teenagers. The plan not only enables EPSDT to make contact with adolescents, but also provides for on-site EPSDT screening by certifying the training sites as EPSDT providers.

C. California

The EPSDT program in California is administered at the county level. Certain counties have developed client outreach methods through other programs and institutions such as:

1. Pre-school Programs: Contracts with the Head Start program and day care centers have been negotiated whereby the county will pay for EPSDT screening of all eligible children enrolled in the pre-school programs.

2. Public Housing: Some counties conduct outreach activities at public housing projects.

3. Hospitals: Outreach is also done through the maternity and pediatic units at hospitals.

D. Pennsylvania

The EPSDT program in Pennsylvania reports that their client outreach efforts do not go beyond the Federal requirements. However, provider recruitment is done through contractors who are paid according to the number of screens that are billed by the providers they recruit.

EPSDT providers include private physicians, group practices, Department of Health Clinics, rural health clinics, family planning clinics for emancipated minors, and health centers. Each provider commits to screening a specific number of recipients.

CSA/WSO _____ *Upon determination of eligibility, copy and forward to PGH Specialist.*

CASE NAME _____ (Last) _____ (First) SOCIAL SECURITY NO. _____ TEL. NO. _____ DATE _____

ADDRESS: Street _____ City/Town _____ Zip Code _____ SOCIAL WORKER _____ LANGUAGE _____

3. LIST ALL INDIVIDUALS WHO NEED FINANCIAL ASSISTANCE: *(Applicant information from Section 1 need not be repeated in Section 3)*

DEP #	WIN STATUS	FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	PLACE OF BIRTH	SEX	RELATIONSHIP TO APPLICANT	ALIEN NUMBER	NAME OF SCHOOL
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									

4. PROJECT GOOD HEALTH: *(List only individuals under 21 including grantee)* *Date of Birth of Grantee if under 21* _____

DEP #	HEALTH INS. CODE	RECEIVES REGULAR MEDICAL CHECK-UP YES/NO	DATE OF LAST MEDICAL CHECK-UP	NAME OF PHYSICIAN OR HEALTH CENTER	IMMUNIZATION SHOTS UP TO DATE YES/NO	RECEIVES REGULAR DENTAL CHECK-UP YES/NO	DATE OF LAST DENTAL CHECK-UP	NAME OF DENTIST OR DENTAL CLINIC	SPECIAL HEALTH PROBLEMS
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
00									

DID WORKER ASSIST APPLICANT IN OBTAINING MEDICAL AND/OR DENTAL SERVICES? ☐ YES ☐ NO

IF YES 1. APPLICANT WAS GIVEN NAME OF HEALTH CARE PROVIDER.

_____ (DOCTOR OR CLINIC) _____ (DENTIST OR CLINIC)

3. MEDICAL TRANSPORTATION AUTHORIZED

DATE _____

DOES APPLICANT DESIRE MORE INFORMATION ON SERVICES PROVIDED BY PROJECT GOOD HEALTH? ☐ YES ☐ NO

2. APPOINTMENT(S) MADE FOR CLIENT

NAME OF PROVIDER _____ DATE _____

NAME OF PROVIDER _____ DATE _____

4. REFERRED FOR:
CHILD CARE SERVICES _____

TRANSLATION SERVICES _____

COMMENTS: _____

APPENDIX H

AREA/BRANCH	LANGUAGE	DATE / /
CASE NAME	SSN - -	DATE OF BIRTH / /
ADDRESS		TELEPHONE -

E. LIST ALL PERSONS FOR WHOM YOU ARE REQUESTING ASSISTANCE (INCLUDE GRANTEE IF REQUESTING ASSISTANCE OR LEGALLY LIABLE FOR MEMBERS OF THE ASSISTANCE UNIT)

DEP NO.	NAME (LAST, FIRST, INITIAL)	RELATIONSHIP TO GRANTEE	DATE OF BIRTH	SEX M/F	SOCIAL SECURITY NUMBER	NAME OF SCHOOL

F. LIST ALL PERSONS LIVING WITH YOU WHO ARE NOT LISTED ABOVE (INCLUDE GRANTEE IF NOT LISTED ABOVE.)

G. PROJECT GOOD HEALTH (PHOTO COPY THIS PAGE AND SEND TO PGH SPECIALIST IF INDICATED BELOW.)

ARE FAMILY MEMBERS UNDER 3 YEARS OF AGE RECEIVING REGULAR MEDICAL CHECKUPS? ☐ YES ☐ NO

HAS EACH FAMILY MEMBER BETWEEN 3 AND 21 YEARS OF AGE RECEIVED:

- MEDICAL CHECKUPS DURING THE LAST 12 MONTHS? ☐ YES ☐ NO
- DENTAL CHECKUPS DURING THE LAST 12 MONTHS? ☐ YES ☐ NO

ARE ALL CHILDREN UP TO DATE ON THEIR IMMUNIZATIONS? ☐ YES ☐ NO

ARE FAMILY MEMBERS UNDER 21 YEARS OF AGE WITH SPECIAL HEALTH CARE PROBLEMS BEING ATTENDED TO BY A MEDICAL OR DENTAL PROVIDER? ☐ YES ☐ NO

LIST MEDICAL AND DENTAL PROVIDERS FOR THE FAMILY:

DOCTOR	DENTIST

IF ANY OF THE ABOVE QUESTIONS WERE CHECKED "NO" - COMPLETE THE FOLLOWING AND SEND TO PGH

WAS RECIPIENT ASSISTED IN SELECTION OF A MEDICAL OR DENTAL PROVIDER? ☐ YES ☐ NO

IF "YES", LIST NAMES:

DOCTOR	DENTIST

WERE APPOINTMENTS MADE FOR RECIPIENT OR FAMILY MEMBERS WITH A MEDICAL OR DENTAL PROVIDER? ☐ YES ☐ NO

IF "YES", LIST:

FAMILY MEMBER	DOCTOR/DENTIST	DATE

WERE REFERRALS MADE FOR:

- CHILD CARE? ☐ YES ☐ NO
- MEDICAL TRANSPORTATION? ☐ YES ☐ NO
- TRANSLATION? ☐ YES ☐ NO

PROJECT GOOD HEALTH (PGH)

FAMILY HEALTH INFORMATION

Complete if any of the persons for whom assistance is requested are under age 21.

Project Good Health is a program that recommends regular medical and dental checkups for children and young adults under age 21. The program also provides the assistance needed to make and keep these appointments and to obtain any subsequent medical and dental treatment that may be necessary.

Your Name _____ Date of Birth _____
(Applicant)

Home Address _____ Tel. _____

Other household members under 21 years of age for whom assistance is requested.

Name: Last First	D.O.B	Sex	Name of Physician or Health Center	Name of Dentist
1.				
2.				
3.				
4.				
5.				

Are your children who are under 3 years of age receiving regular care from a doctor or health center? By "regular care" we mean that the child visits the doctor 6 times during the first year of life, 3 during the second year, and twice during the third year. . . . . Yes___ No___ N/A___

Are your children who are between 3 and 10 years of age receiving medical checkups each year? . . . . . Yes___ No___ N/A___

Are all individuals who are over 10 and under 21 years of age receiving medical checkups at least once every **two** years? . . . . . Yes___ No___ N/A___

Do all family members 3 years of age or older receive a dental checkup each year? . . . . . Yes___ No___ N/A___

It is important to have the proper immunization against polio, diphtheria, tetanus, whooping cough, measles, mumps and rubella.
Are all family members up to date in their immunization shots? . . . . . Yes___ No___

Does any member of the family have any special health problems?
If yes, Please indicate name of family member and describe problem. . . . . Yes___ No___

_____

_____

_____

Are these problems being treated by a doctor, dentist or health center? . . . . . Yes___ No___

REQUEST FOR PGH ASSISTANCE

If persons under age 21 are determined eligible for medical assistance, do you need help in obtaining health care for them? If yes, please answer the following questions: . . . . . Yes_____ No_____

A. Do you need help in selecting a doctor or dentist? . . . . . Yes_____ No_____

B. Do you need help in making an appointment with a doctor or dentist? . . . . . Yes_____ No_____

C. Do you have a transportation problem that prevents you from keeping appointments with a doctor and/or dentist? . . . . . Yes_____ No_____

D. Does the lack of babysitting prevent you from keeping appointments with a doctor and/or dentist for family members under 21? . . . . . Yes_____ No_____

E. Do you have trouble speaking or reading English? . . . . . Yes_____ No_____

If yes, does this prevent you from receiving health care services? . . . . . Yes_____ No_____

What language do you speak and read?_____

F. Is there any other problem which prevents you from obtaining health care for family members under 21? . . . . . Yes_____ No_____

If yes, please explain_____

_____

G. Do you desire more information on services provided by Project Good Health? . . . . Yes_____ No_____

FOR DEPARTMENT USE ONLY

Date referred to PGH Specialist_____

List any PGH services performed by eligibility worker (if any).

_____

_____

APPENDIX K

Persons Interviewed

Department of Public Welfare

Joanne Bluestone
Associate Commissioner for Medical Payments

Jan Singer
former Director, Managed Health Programs

Virginia Jacobs
Director, Coordinated Health Programs

Lynne Karsten
Director, Project Good Health

Daniel Shea
Project Good Health

Elizabeth Pressman
Project Good Health

Rosemary Pellettieri
Project Good Health

Carol Weisenberg
Project Good Health

Project Good Health Supervisors, Specialists and Technicians

Department of Public Health

Judy Gorbach
Director, Adolescent Health Services

Winnie Willis
High Risk Infant Identification Program

Linda Yeomans
Southeast Asian Project Coordinator
Special Supplemental Food Program for Women, Infants, and Children

Physicians

Edward N. Bailey, M.D.
Springfield, MA

Cyril Bergman, M.D.
Fitchburg, MA

Sidney Brodie, M.D.
Brookline, MA

Gerald W. Hazard, M.D.
Hyannis, MA

Elizabeth MacDonald, M.D.
Lynn, MA

David Maltz, M.D.
Cohasset, MA

Edward A. Penn, M.D.
Fall River, MA

Sandy Pitelli, M.D.
Harvard, MA

George Porter, M.D.
Pittsfield, MA

Robert Younes, M.D.
Boston, MA

Arnold Gurwitz, M.D.
Worcester, MA

John Hubbell, M.D.
Boston, MA

Pat Moffatt, M.D.
Auburndale, MA

William Winter, M.D.
Dedham, MA

Other Medical Care Providers

Tristram Blake
Executive Director, South End Community Health Center

Dan Driscoll
Administrator, Neponset Health Center

Kathryn Kunze
Clinical Coordinator, Neponset Health Center

Patricia Edraos
Director of Health Resources,
Massachusetts League of Community Health Centers

Alice Verhoeven
Planned Parenthood Clinic, Worcester

Frances Anthas
Family Planning Services of Central Massachusetts

Bea Morreo
Cambridge Rindge and Latin Health Clinic

Bridget Hanson, M.D.
Cambridge Hospital

Other State EPSDT Programs

Joe Constantine
Hartford Public Schools

Donald Sullivan
Rhode Island

Pat Massopust
Minnesota

Carol Springer
California

Julie Elson
New York

Jo Ellen Cusick
New York

Joyce Rodriquez
Michigan

Pat Burke
Vermont

Other Persons

Sara Rosenbaum
Director, Child Health, Children's Defense Fund, Washington, D.C.

Mary Gallagher
Massaachusetts Law Reform Institute

Barry Ensminger
Office of the City Council President, New York City

Deborah Klein Walker
Harvard School of Public Health